DEPARTMENT OF HEALTH AND HUMAN SERVICES

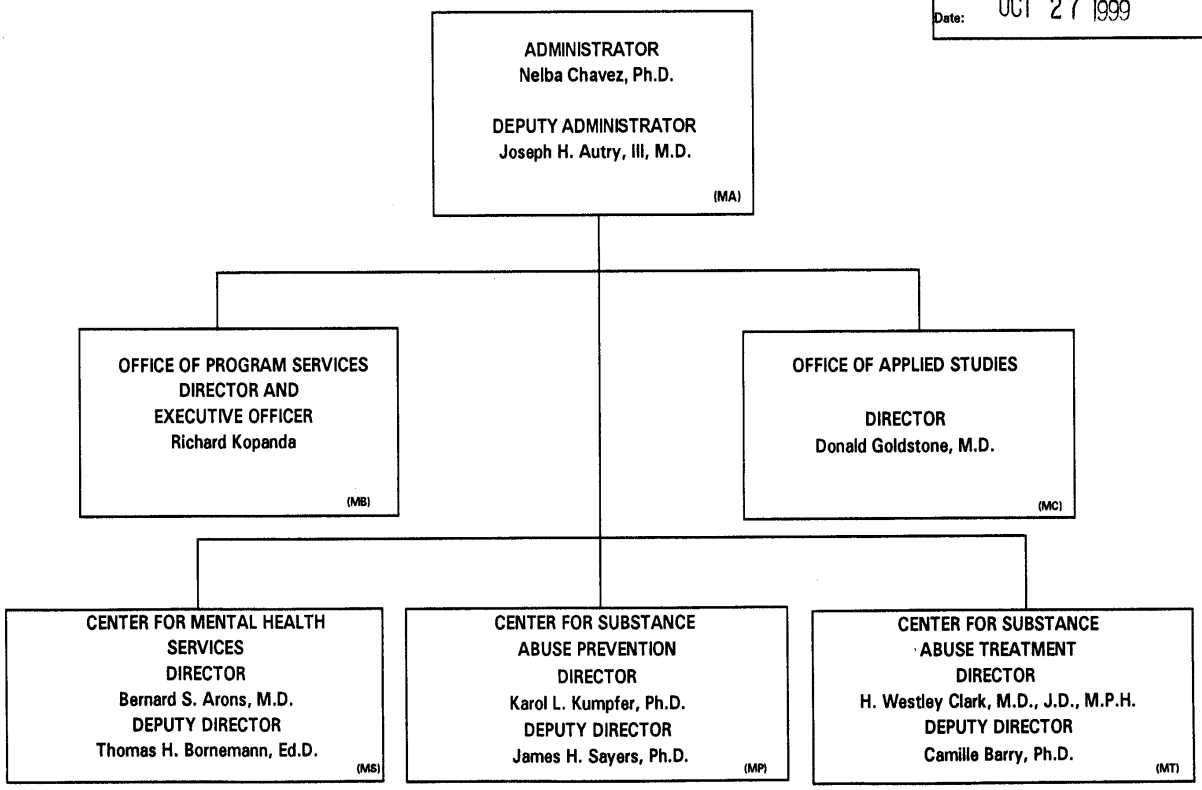
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Fiscal Year 2001 Budget **Page**

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Approved:
Date: OCT 27 1999



Substance Abuse and Mental Health Services Administration

Appropriation Language

For carrying out titles V and XIX of the Public Health Service Act with respect to substance abuse and mental health services, the Protection and Advocacy for Mentally Ill Individuals Act of 1986, and section 301 of the Public Health Service Act with respect to program management, [$2,654,953,000] $2,823,016,000: Provided, That in addition to amounts provided herein, $12,000,000 shall be available from amounts available under section 241 of the Public Health Service Act, to carry out the National Household Survey on Drug Abuse. *(Department of Health and Human Services Appropriation Act, 2000, as enacted by section1000(a)(4) of the Consolidated Appropriations Act,2000 (P.L. 106-113).)*

Substance Abuse and Mental Health Services Administration

Amounts Available for Obligation

	FY 1999 Actual	FY 2000 Appropriation	FY 2001 Estimate
Appropriation:			
Labor/HHS-Annual	$2,488,005,000	$2,654,953,000	$2,823,016,000
Subtotal, adjusted budget authority	2,488,005,000	2,654,953,000	2,823,016,000
Reduction pursuant to P.L. 106-113	---	(3,085,000)	---
Transferred to Other Accounts	(792,000)	---	---
Rescission P.L. 105-277	(426,000)	---	---
Unobligated balance expiring	(559,856)	---	---
Offsetting Collections from:			
Federal Sources	33,263,040	40,000,000	40,000,000
Total obligations	$2,519,490,184	$2,691,868,000	$2,863,016,000

Substance Abuse and Mental Health Services Administration
Summary of Changes

2001 Estimate	$2,823,016,000
2000 Current Estimate	-2,651,868,000
Net Change	+$171,148,000

	FY 2000 Current Estimate		Change from Base	
	FTE	Budget Authority	FTE	Budget Authority
Increases:				
A. Built-in:				
1. Annualization of 2000 pay costs	--	$51,683,000	--	+$638,000
2. Within grade pay increases	--	51,683,000	--	+930,000
3. Increase for January 2001 pay raise at 3.7%	--	51,683,000	--	+1,512,000
4. Increased rental payments to GSA	--	4,135,000	--	+315,000
5. Increase in overhead charges	--	59,054,000		+707,000
Subtotal, Built-in Increases	--	---	--	+4,102,000
B. Program:				
1. Targeted Capacity Expansion	--	194,590,000	--	+83,778,000
2. Children's Mental Health Services Program	--	82,763,000	--	+4,000,000
3. Protection and Advocacy Program	--	24,903,000	--	+1,000,000
4. PATH Homeless Formula Grants	--	30,883,000	--	+5,000,000
5. Mental Health:				
a. Mental Health Block Grant	--	356,000,000	--	+60,000,000
6. Substance Abuse:				
a. Substance Abuse Block Grant	--	1,600,000,000	--	+31,000,000
7. Program Management	--	59,054,000	--	+889,000
Subtotal, Program Increases	--	---	--	+185,667,000
Total Increases	--	---	--	+189,769,000
Decreases:				
A. Program:				
1. Knowledge Development and Application:				
a. Substance Abuse Prevention -- program reduction	--	59,541,000	--	-9,519,000
b. Substance Abuse Treatment -- program reduction	--	100,259,000	--	-5,000,000
B. Program Management:				
1. One day less pay	--	51,683,000	--	-199,000
2. Decrease due to absorption of built-in mandatory increases	--	59,054,000	--	-3,903,000
Subtotal, Program Decreases	--	---	--	-18,621,000
Total Decreases	--	---	--	-18,621,000
Net Change	--	---	--	+$171,148,000

Substance Abuse and Mental Health Services Administration

Budget Authority by Activity

(Dollars in thousands)

Program/Activity	FY 1999 Actual	FY 2000 Pre-rescission Appropriation	FY 2000 Final Appropriation	FY 2001 Estimate	Increase or Decrease
Knowledge Development and Application	**$289,307**	**$299,263**	**$296,675**	**$282,156**	**-$14,519**
Mental Health (Non-add)	*(96,419)*	*(138,982)*	*(136,875)*	*(136,875)*	*(---)*
Substance Abuse Prevention (Non-add)	*(77,591)*	*(60,022)*	*(59,541)*	*(50,022)*	*(-9,519)*
Substance Abuse Treatment (Non-add)	*(115,297)*	*(100,259)*	*(100,259)*	*(95,259)*	*(-5,000)*
Targeted Capacity Expansion	**133,307**	**194,590**	**194,590**	**278,368**	**+83,778**
Mental Health (Non-add)	---	---	---	*(30,000)*	*(+30,000)*
Substance Abuse Prevention (Non-add)	*(78,218)*	*(80,283)*	*(80,283)*	*(85,207)*	*(+4,924)*
Substance Abuse Treatment (Non-add)	*(55,089)*	*(114,307)*	*(114,307)*	*(163,161)*	*(+48,854)*
High Risk Youth	**6,991**	**7,000**	**7,000**	**7,000**	**---**
Children's Mental Health Services	**77,909**	**83,000**	**82,763**	**86,763**	**+4,000**
Protection & Advocacy	**22,949**	**25,000**	**24,903**	**25,903**	**+1,000**
PATH Homeless Formula Grants	**25,991**	**31,000**	**30,883**	**35,883**	**+5,000**
Mental Health Block Grant	**288,816**	**356,000**	**356,000**	**416,000**	**+60,000**
Substance Abuse Block Grant	**1,585,000**	**1,600,000**	**1,600,000**	**1,631,000**	**+31,000**
Program Management	**56,517**	**59,100**	**59,054**	**59,943**	**+889**
(FTE's -- Non add)	**(561)**	**(614)**	**(614)**	**(614)**	**(---)**
TOTAL, SAMHSA	**$2,486,787**	**$2,654,953**	**$2,651,868**	**$2,823,016**	**+$171,148**
National Data Collection (1% Evaluation funds)	---	---	---	**12,000**	**+12,000**
TOTAL, SAMHSA Program Level	**$2,486,787**	**$2,654,953**	**$2,651,868**	**$2,835,016**	**+$183,148**

FY 2001 BUDGET SUBMISSION
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
OBJECT CLASSIFICATION
(Dollars in Thousands)

Object Class	FY 2000 Final Appropriation	FY 2001 Estimate	FY 2001 +/- FY 2000
Direct Obligations			
Personnel Compensation:			
Full Time Permanent (11.1)	$39,909	$42,184	+$2,275
Other than Full-Time Permanent (11.3)	1,384	1,468	+84
Other Personnel Compensation (11.5)	1,200	1,266	+66
Subtotal, Personnel Compensation	**42,493**	**44,918**	**+2,425**
Civilian Personnel Benefits (12.1)	9,190	9,711	+521
Subtotal, Pay Costs	**51,683**	**54,629**	**+2,946**
Travel (21.0)	1,700	1,800	+100
Transportation of Things (22.0)	100	102	+2
Rentals to GSA (23.1)	4,135	4,450	+315
Rental Payments to Others (23.2)	12	13	+1
Communications, Utilities and Misc. Charges (23.3)	1,888	1,954	+66
Printing and Reproduction (24.0)	3,767	3,899	+132
Consulting Services (25.1)	10,922	12,122	+1,200
Other Services (25.2)	175,615	182,008	+6,393
Purchase from Gov't Accounts (25.3)	48,913	51,363	+2,450
Other Contractual Services (25.0)	235,450	245,493	+10,043
Supplies and Materials (26.0)	312	322	+10
Equipment (31.0)	1,749	1,776	+27
Grants, Subsidies, and Contributions (41.0)	2,349,098	2,506,530	+157,432
Insurance Claims & Indemnities	1,974	2,048	+74
Subtotal Non-Pay Costs	**2,600,185**	**2,768,387**	**+168,202**
Total Direct Obligations	**$2,651,868**	**$2,823,016**	**+171,148**

FY 2001 BUDGET SUBMISSION
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
SALARIES AND EXPENSES
(Dollars in Thousands)

Object Class	FY 2000 Final Appropriation	FY 2001 Estimate	FY 2001 +/- FY 2000
Personnel Compensation:			
Full Time Permanent (11.1).....	$39,909	$42,184	+$2,275
Other than Full-Time Permanent (11.3).....	1,384	1,468	+84
Other Personnel Compensation (11.5).....	1,200	1,266	+66
Subtotal, Personnel Compensation	**42,493**	**44,918**	**+2,425**
Civilian Personnel Benefits (12.1).....	9,190	9,711	+521
Subtotal, Pay Costs	**51,683**	**54,629**	**+2,946**
Travel (21.0).....	1,700	1,800	+100
Transportation of Things (22.0).....	100	102	+2
Rental Payments to Others (23.2).....	12	13	+1
Communications, Utilities and Misc. Charges (23.3).....	1,888	1,954	+66
Printing and Reproduction (24.0).....	3,767	3,899	+132
Other Contractual Services:			
Consulting Services (25.1).....	10,922	12,122	+1,200
Other Services (25.2).....	97,071	111,166	+14,095
Purchases from Gov't Accounts (25.3).....	48,913	51,363	+2,450
Subtotal, Other Contractual Services (25.0)	**156,906**	**174,651**	**+17,745**
Supplies and Materials (26.0).....	312	322	+10
Subtotal Non-Pay Costs	**164,685**	**182,741**	**+18,056**
Total Salaries and Expenses	**$216,368**	**$237,370**	**+21,002**

Significant Items for House, Senate, and Conference Appropriations Committee Reports

2000 House Report No. 106-370

Item: Minority Fellowship Program -- The Committee recognizes the role that the Minority Fellowship program plays in training mental health professionals to provide services to individuals who would otherwise go untreated and urges SAMHSA to enhance its efforts in this program through its three Centers. (Page 118)

Action Taken or to be Taken

SAMHSA plans to continue support for the Minority Fellowship Program at the same level as FY 1999.

Item: Substance abuse treatment outreach -- The Committee encourages SAMHSA to develop and strengthen substance abuse treatment and prevention programs for Native Americans, Asian Americans, Native Hawaiians, and other Pacific Islanders to include an HIV component. Programs should also be strengthened through the development of increased linkages between HIV/AIDS programs and Native Americans, Asian Americans, Native Hawaiians, and other Pacific Islander substance abuse treatment programs. (Page 121)

Action Taken or to be Taken

In FY 1999, 33% of the Targeted Capacity Expansion grants were awarded to Native Americans and Native Alaskan sites and one Targeted Capacity Expansion HIV grant was awarded to identify Native Hawaiian women who are abusing alcohol and other drugs and are at risk of HIV/AIDS. It is expected that all of these programs will be continued in FY 2000. In addition, CSAT would expect to award another approximately $5 million in new grants to programs serving these populations.

Other activities occurring in the Pacific Basin include a Pacific Island Epidemiological and Psychological Research and Training Project to establish a research and teaching infrastructure for studies of epidemiology, health surveillance and cultural contexts related to alcohol consumption, substance abuse and co-morbid disorders in Pacific Island jurisdictions. The infrastructure will consist of Collaborative Workgroups directed by indigenous/local personnel. There is also a Pacific Island Medical Officer Training Project to train medical personnel in the early recognition of substance abuse/mental health problems and to facilitate effective linkages between health, substance abuse and mental health professionals.

CSAT is sponsoring a conference of leading Asian American and other researchers designed to discuss, identify and publish best treatment practices for Asian Americans via a Technical Assistance Publication (TAP).

Item: Treatment outreach -- The Committee urges SAMHSA to enhance funding in all programs for cultural competency education and training of health care providers and culturally and linguistically appropriate outreach and services to local minority communities, including Asian American communities. (Page 121)

Action Taken or to be Taken

The Addiction Technology Transfer Centers (ATTCs) offer an education series on cultural competency. The courses introduce current theories and practices in multi cultural counseling to mental health and addiction treatment/prevention practitioners. CSAT also has produced publications on the issue of cultural competence. The most recent, *Cultural Issues in Substance Abuse Treatment*, was published in 1999. Several of the Treatment Improvement Protocols (TIPs) address the issue as well. These include, *Treatment for HIV-Infected Alcohol and Other Drug Abusers* (TIP 15), *Combining Alcohol and Other Drug Abuse Treatment with Diversion for Juveniles in the Justice System* (TIP 21), and *Substance Abuse Treatment and Domestic Violence* (TIP 25).

Other efforts include a collaboration with the Office of Minority Health, the National Institute on Drug Abuse, the Health Resources and Services Administration and the Interamerican College of Physicians and Surgeons to train clinicians and health care workers serving predominantly Spanish-language clients.

Cultural competence is also an important criterion in the award of new grants. Factors that are considered include involvement with the target population, training and staffing in gender/age/cultural competence, language, materials, and community representation. There should be objective evidence that the grant applicant organization understands the cultural aspects of the community that will contribute to the program's success.

Item: Treatment outreach -- The Committee encourages SAMHSA to study and develop public health interventions related to improving the health and health care of underserved, impoverished, and high-risk children, teens, adults, and the elderly living in public housing. These interventions should focus on education for health promotion and identification of illness at early stages, specialized mental health and substance abuse services, and enhance the mental health and substance abuse assessment and treatment practices of community health care and social service providers. (Pages 121).

Action Taken or to be Taken

The Knowledge Development and Application program is designed to support development and testing of new and innovative treatment approaches and to disseminate information on those systems shown to be most effective, promoting the adoption of best practices. Projects funded under the KDA program as well as Targeted Capacity Expansion do support substance abuse treatment services for the underserved, high-risk children, youth and adults, some of whom are living in public housing.

The Addiction Technology Transfer Centers and other training efforts funded by CSAT support education efforts for health care, social service providers, treatment providers and a variety of other related service providers in the early identification, assessment and treatment of alcohol and drug addiction.

Item: HIV/AIDS funding -- The Committee is concerned with the growing number of HIV/AIDS reported cases in the Hispanic community, the African-American community, the Native-American community and other affected ethnic and minority populations. To address this growing epidemic, the Committee urges SAMHSA to provide funding for initiatives to address the needs of these communities. (Pages 121-122).

Action Taken or to be Taken

In FY 2000, CSAT plans to continue the first round of Targeted Capacity Expansion HIV grants that were awarded in 1999. This initiative funds HIV/AIDS projects which target African American, Hispanic and other ethnic/racial minority communities. In addition to those 35 continuation awards, CSAT plans to fund a new round of TCE HIV grants, approximately 40-45 new awards. CSAT also expects to continue the AIDS Outreach program which focuses primarily on adolescent African American and Hispanic females.

Item: HIV/AIDS funding -- The Committee encourages Federal HIV/AIDS services and prevention funds be responsive to the demographic trends of the epidemic. (Page 122).

Action Taken or to be Taken

In FY 1999, CSAP initiated a major Substance Abuse and HIV/AIDS Prevention for Youth and Women of Color Initiative to focus on providing HIV prevention and substance abuse prevention services to African American and Hispanic youth and women, and other women of color. CSAP will continue these efforts in FY 2000 and beyond as funds are available. The CSAP program represents a comprehensive effort to fund community-based organizations, Historical Black Colleges and Universities, Hispanic Colleges and Universities, Faith communities, and other coalitions and/or partnerships for the purpose of strengthening the integration of HIV prevention and substance abuse prevention services at the local level. This initiative also works with CSAP's Centers for the Application of Prevention Technology (CAPTs) to enable them to integrate HIV prevention into their substance abuse prevention materials and curricula and to help build capacity within the CAPTs to provide training and technical assistance to community based organizations and other service providers in the hardest hit communities. Additionally, the HIV/AIDS initiative will partner with national organizations in several key areas including accessing and retaining minority youth and women in prevention programs and ensuring the applicability and feasibility of proposed community programs.

In FY 2000, CSAT plans to continue the first round of Targeted Capacity Expansion HIV grants that were awarded in 1999. This initiative funds HIV/AIDS projects which target African American, Hispanic and other ethnic/racial minority communities. In addition to those 35 continuation awards, CSAT plans to fund a new round of TCE HIV grants, approximately 40-45 new awards. Special emphasis is given to women,

women and their children, adolescents, men who inject drugs and men who have sex with men and inject drugs. This program seeks to address gaps in treatment capacity, as well as increase accessibility and availability of substance abuse treatment and HIV/AIDS services to affected racial and ethnic communities. Target communities are located in Metropolitan Statistical Areas or States with an annual AIDS case rate of 20/100,000 or 10/100,000. Funding is available for three years.

Significant Items for House, Senate, and Conference Appropriations Committee Reports

2000 Senate Report No. 106-166

Item: Substance abuse in rural and native communities -- The Committee remains concerned by the disproportionate presence of substance abuse in rural and native communities, particularly for American Indian, Alaska Native and native Hawaiians communities. The Committee reiterates its belief that funds for prevention and treatment programs should be targeted to those persons and communities most in need of service. Therefore, the Committee has provided sufficient funds to fund projects to increase knowledge about effective ways to deliver services to rural and native communities. Within the funds reserved for rural programs, the Committee intends that $8,000,000 be reserved for CSAP grants, and $12,000,000 be reserved for CSAT grants. (Page 184).

Action Taken or to be Taken

CSAP has earmarked $8 million in funds to support substance abuse prevention in rural and native communities. At least $3 million will continue current efforts while $5 million will support new awards targeted to rural and native communities most in need.

In FY 1999, CSAT awarded approximately $3.9 million in Knowledge Development and Application funding and $11.3 million in Targeted Capacity Expansion funding projects targeting rural populations, Native Americans and Alaskans. It is expected that all of these programs will be continued in FY 2000. CSAT expects to provide an additional $9 million in funding for programs serving these populations.

Item: Fetal Alcohol Syndrome (FAS) prevention -- Last year, the Fetal Alcohol Syndrome Prevention and Services Act was enacted, authorizing a competitive grant program to develop urgently needed prevention and education strategies to reduce the number of children affected by Fetal Alcohol Syndrome [FAS]. These grants are also to be used to develop treatment strategies to assist parents and families as they cope with the impacts of FAS. The Committee urges the Department to fund grants in CSAP and CSAT to address FAS and its effects. The Committee further believes that these funds should be targeted to areas that demonstrate significant need and have a high incidence or risk of alcohol-related birth defects. (Page 184)

Action Taken or to be Taken

CSAP is working with a regional consortium of South Dakota, North Dakota, Minnesota, and Montana to develop a comprehensive prevention program to lower the incidence of FAS in these states which have demonstrated high need. CSAP plans to award approximately $2.76 million in FY 2000 for this purpose.

Item: Mental health services for school children -- The Committee has included additional funds to continue and expand mental health services for schoolchildren that are at risk of exhibiting violent behavior.

Last year, after the tragic shootings at a number of schools across the nation, the Congress provided funds to begin to address the problem of youth violence. Among other things, the Committee believes that mental health counseling for troubled youth can help prevent violent acts, and is therefore providing additional funds to help schools in that cause. It is again expected that SAMHSA will collaborate with the Department of Education to continue a coordinated approach. (Page 185)

Action Taken or to be Taken

CMHS will continue and expand its program, in collaboration with the Department of Education, to support the delivery and improvement of mental health services in our nation's schools. This coordinated approach is enabling school districts to implement a wide range of early childhood development, early intervention and prevention, and mental health treatment services to assist in preventing violence among children.

Item: Technical assistance for use in training programs -- The Committee is pleased with the successful collaboration between the Center for Mental Health Services and the Bureau of Health Professions in HRSA to fund interdisciplinary health professions training projects, including training of behavioral and mental health professionals, for practice in managed care/primary care settings and urges that this joint effort be continued. The Committee encourages both agencies to develop technical assistance for use in health professions training programs for the purpose of enhancing primary care interdisciplinary models of practice. These efforts should be focused upon rural native populations that are at-risk for the problems most encountered by these health professionals. (Pages 185-186)

Action Taken or to be Taken

CMHS is collaborating with HRSA to continue an initiative on multi-disciplinary training of mental health professionals in primary care settings. CMHS also continues to support the Minority Fellowship Program which facilitates the entry of ethnic minority students into mental health careers and increases the number of psychiatrists, psychologists, social workers and nurses trained to teach, administer and provide direct mental health and substance abuse services to ethnic minority groups. With a program focused on underserved minority populations of Native Americans, Asian Pacific Americans, African Americans, and Hispanic Americans, the Minority Fellowship Program (MFP) encourages training to meet personnel shortages in rural and urban minority communities.

Item: Expansion of Knowledge Development and Application program --. . . The Committee supports extending the Knowledge Development and Application Program to all 50 states, territories, and tribal communities. The Committee encourages the development of partnerships with local communities to further expand this program. (Page 186)

Action Taken or to be Taken

The CMHS Knowledge Development and Application Program has awarded grants in all 50 States and more than 20 tribes. Last year, the first grant to a territory was awarded. This program has expanded the development of partnerships with local communities through programs such the Youth Violence Prevention,

Community Action and Consumer and Family Network programs. KDA are also extended to all state and territories through the PATH technical assistance program. Today, more than 225 grants are in place throughout the Nation that extend KDA results to people who need improved mental health services. CMHS continues to provide technical assistance to states, territories and tribal communities and encourages them to submit grant applications for our programs.

Item: Gambling -- The Committee recently heard testimony about the tragic results of addictive and pathological gambling. Gambling has destroyed the lives of many American families. A recent report by the National Gambling Impact Study Commission found that 15.4 million Americans are either pathological or problem gamblers. Problem gambling burdens not only the addicted individual and his or her family, but society as well. Costs incurred can include unemployment benefits caused by the loss of a job, physical and mental health problems, domestic violence, and child abuse and neglect. The Committee urges CMHS to conduct demonstration projects to determine effective strategies and best practices for preventing and treating addictive gambling. (Page 186)

Action Taken or to be Taken

CMHS is planning a series of activities to examine effective strategies to address pathological gambling with a focus on the analysis of the prevalence and identification of such problems, the effectiveness of prevention and treatment strategies, and the implications for public education, policy making, and professional training.

Item: Self-sufficiency for sufferers of mental illness -- The Committee recognizes the extraordinary obstacles facing individuals with mental illness and co-occurring psychiatric disorders towards achieving economic self-sufficiency. The Committee is aware of the Community Advocacy Training Services in providing training and technical assistance to persons with such disorders. The Committee believes that the Department should consider funding demonstrations that endeavor to help individuals with mental illnesses lead rewarding and productive lives. (Page 186)

Action Taken or to be Taken

CMHS has undertaken a number of efforts to promote the self-sufficiency of persons with mental illness. This includes the Employment Intervention Demonstration Program to determine effective approaches for such persons to attain and maintain meaningful employment as well as the Consumer Operated Services Program to examine how such efforts can be successful. In addition, CMHS provides support for technical assistance to assist persons with mental illness to develop self-help approaches to improve the quality of their lives.

Item: AIDS demonstration projects -- . . . The Committee commends the -- Center for Mental Health Services for its commitment in disseminating knowledge gained from these demonstration projects. The Committee urges the center to maintain its support for projects that provide direct mental health services while at the same time using the findings from previous projects to develop new knowledge in this area. The Committee again commends CMHS for its leadership in working cooperatively in demonstrating the

efficacy of delivering mental health services to individuals affected by and living with HIV/AIDS. The Committee encourages the Secretary to maintain these agencies' support for this program. (Page 187).

Action Taken or to be Taken

CMHS plans to continue funding in collaboration with HRSA, NIAAA, NIDA, NIMH and CSAT for the HIV/AIDS Outcome Cost Study begun in FY 1998. This program is based on the findings of the AIDS Demonstration program. The program studies treatment adherence, health outcomes, and associated costs in providing mental health services, substance abuse services, and primary health care services for people living with HIV/AIDS.

Item: Protection and advocacy -- The Committee has learned that patients with mental illnesses have died or received life-threatening injuries in treatment facilities because of improper restraints and seclusion. The Committee has provided additional resources for protection and advocacy so that these deaths can be investigated and future incidences can be prevented. (Page 188).

Action Taken or to be Taken

CMHS continues to administer the Protection and Advocacy for Individuals with Mental Illness (PAIMI) program which supports agencies in all States and territories to investigate allegations of abuse and neglect - including deaths due to improper use of restraints and seclusion - in residential facilities which provide mental health services. Additional resources will assist these agencies to expand their current activities.

Item: Substance abuse treatment services -- The Committee reiterates its concern about the disproportionate impact of substance abuse in rural and native communities, and has included $12,000,000 for native and rural CSAT programs. The Committee again raises concern about the severe shortage of substance abuse treatment services in the State of Alaska for Native Alaskans, the pressing need to continue support of Alaska programs, and the need to develop knowledge about effective techniques for treating substance abuse in native populations. The Committee, therefore, expects that the increase provided will be reasonably allocated between existing programs and initiating new programs, especially in Alaska. (Page 189).

Action Taken or to be Taken

In FY 1999, CSAT awarded approximately $3.9 million in Knowledge Development and Application funding and $11.3 million in Targeted Capacity Expansion funding projects targeting rural populations, Native Americans and Alaskans. It is expected that all of these programs will be continued in FY 2000. CSAT expects to provide an additional $9 million in funding for programs serving these populations, with approximately one-third of the new funding going to programs in Alaska.

Item: Methamphetamine abuse in Iowa -- The Committee understands that methamphetamine abuse continues to be a major problem in many areas of the country, in particular, the South and the Midwest. The State of Iowa is experiencing a particularly high incidence of methamphetamine abuse. The Committee

believes that additional funds could expand the number of prevention and treatment demonstration projects in Iowa and other parts of the Midwest. School-based prevention demonstration projects would teach the dangers of methamphetamine abuse and addiction, using methods that are effective and evidence-based and include initiatives that give students the responsibility to create their own anti-drug abuse education programs for their schools. Treatment demonstrations would carry out planning, establishing, or administering evidence-based methamphetamine treatment programs that are designed to assist individuals to quit their use of methamphetamine and remain drug-free. (Page 190)

Action Taken or to be Taken

In FY 1999, CSAT funded a Statewide methamphetamine treatment initiative headed by the Single State Agency for Alcohol and Drug Abuse. This initiative was funded as part of the Targeted Capacity Expansion initiative. CSAT expects to continue this project in FY 2000 and encourages applications from the State of Iowa and other areas in the Midwest for funding under the FY 2000 Targeted Capacity Expansion announcement.

CSAT is also coordinating with the Office of Justice Programs (OJP), Department of Justice, to identify Targeted Capacity Expansion and other CSAT grants in areas in which OJP is seeking to establish methamphetamine treatment programming.

Item: Substance abuse by the homeless -- The Committee remains concerned that substance abuse among the nation's homeless population remains a serious problem that receives limited attention. Existing addiction services are not adequately reaching the homeless population and are not adequately addressing their unique needs and life circumstances. Of the funds provided, the Committee encourages the Department to support the development and expansion of addiction services targeted to the homeless. (Page 190).

Action Taken or to be Taken

CSAT is currently co-funding a Homelessness Prevention Program with CMHS that addresses the issue of substance abuse and mental health disorders among homeless populations. In FY 2000, CSAT will be announcing a new Exemplary Treatment Models initiative targeted to co-occurring populations and expects that some of the funds available will go to programs which serve homeless populations in need of substance abuse treatment services. The Targeted Capacity Expansion Program includes the homeless as a population of concern and encourages applications which provide services for this population.

Item: Heroin addiction -- The Committee is concerned about the devastating effects of heroin use on individuals and their families. For decades, methadone has been the primary method of treating heroin addiction. The Committee has heard reports that expanding the availability of methadone would help additional heroin addicts receive treatment. The Committee is aware of a proposed rule to revise the conditions for the use of narcotic drugs in maintenance and detoxification treatment of opioid addiction. Comprehensive monitoring of the implementation of this regulation in conjunction with a study by the

Secretary evaluating the possibility and effects of expanding the use of methadone would be valuable to the Committee. (Page 191)

Action Taken or to be Taken

CSAT supports the need to expand pharmacotherapy treatment for the opiate addicted population and would support a feasibility study to examine in depth the barriers to expanding treatment capacity as well as the potential effects. Such a study was not anticipated in our planning process for FY 2000 and FY 2001, but CSAT will examine existing resources to determine whether conducting such a study is possible.

Item: Mexican black tar heroin abuse -- The Committee understands that Mexican black tar heroin abuse has become a major problem in many areas of the country, in particular, Southwestern border states and major metropolitan areas in the West. The State of New Mexico has experienced an extremely high incidence of Mexican black tar heroin abuse in Rio Aerobe and Santa Fe counties. The Committee believes that funding for a demonstration project in Rio Aerobe and Santa Fe counties would yield valuable information concerning how to treat this deadly addiction. The Committee believes that a demonstration project to determine ways to prevent this addiction would also yield valuable benefits. (Pages 191-192)

Action Taken or to be Taken

CSAP staff have begun preparations for a demonstration project in Rio Aerobe and Santa Fe counties to prevent the use of Mexican black tar heroin.

Item: Substance abuse among high risk youth -- . . ..The Committee is highly concerned about the extent of substance abuse among high risk youth. This population is vulnerable to initiating criminal activity against people and property, especially following the acute and chronic use of illicit substances and the abuse of alcohol. These grants are intended to strengthen local capabilities in confronting the complex interrelationships between substance and alcohol abuse and other activities that may predispose young individuals toward criminal, self-destructive, or antisocial behavior. (Page 192).

Action Taken or to be Taken

CSAP's Project Youth Connect is targeted toward high-risk youth, in particular, those youth who are at high risk for becoming substance abusers and/or involved in the criminal justice system. The program is designed to prevent or reduce substance abuse or delay its onset in youth (9- to 15-years old) by improving: school bonding and academic performance; family functioning and overall life management skills.

In FY 2001 CSAP will continue support of Project Youth Connect mentoring/advocacy models that focus on youth ages 9 - 15 and their families with particular emphasis on the after school hours. Research conducted by the Federal Bureau of Investigation reveals that the critical time period when youth are most susceptible to engaging in delinquent behavior peaks between the hours of 3 and 7 p.m. It is anticipated

that this intervention will be effective in reducing substance abuse and related violence as well as improving community attitudes about youth and enhancing the system of support available

Item: Drug abuse prevention -- The Committee believes that prevention programs need to start when children are young, and need to continue to help children make successful transitions. The Committee has included sufficient funds for evaluations of established school-based early prevention and transition programs and continues to be supportive of the efforts of the Corporate Alliance for Drug Education [CADE] which has been operating a program providing education and prevention services to 120,000 elementary school-aged children in Philadelphia. (Page 192).

Action Taken or to be Taken

CSAP plans to continue to support to the Corporate Alliance for Drug Education (CADE) in Fiscal Year 2000. CSAP has a mechanism in place for support of CADE and work has continued uninterrupted.

Significant Items for House, Senate, and Conference Appropriations Committee Reports

2000 Conference Report No. 106-479

Item: Effectiveness of a comprehensive mental health system-- Mental health services for children and adolescents could be strengthened by a comprehensive system that measures the quality and effectiveness of these services. The Center's Committee on Child and Adolescent Outcomes has supported the collaboration between Vanderbilt University and Australia in developing such an evaluation system in the United States. The Department is urged to continue this collaboration. (Page 609)

Action Taken or to be Taken

CMHS continues to support the collaboration between Vanderbilt University, Australia and others in developing outcome measures that examine the quality and effectiveness of mental health services for children and adolescents.

Item: Mental health services for school-age children -- . . .The conference agreement has doubled funding for mental health services for school-age children, as part of an effort to reduce school violence. It is intended that $80,000,000 be used for the support and delivery of school-based and school-related mental health services for school-age youth. It is intended that the Department will continue to collaborate its efforts with the Department of Education to develop a coordinated approach. (Page 609)

Action Taken or to be Taken

CMHS will continue and expand its program, in collaboration with the Department of Education, to support the delivery and improvement of mental health services in our nation's schools. This coordinated approach is enabling school districts to implement a wide range of early childhood development, early intervention and prevention, and mental health treatment services to assist in preventing violence among children.

Item: CSAT programs -- The conference agreement provides $214,566,000 for knowledge development and application instead of $136,613,000 as proposed by the House and $226,868,000 as proposed by the Senate. Within the total provided: $200,000 is for the Center Point Program in Marin County, California, for substance abuse and related services to high-risk individuals and families; and $1,000,000 is for the San Francisco Department of Public Health's treatment on Demand program. Within the total provided, sufficient funds are included to expand the residential treatment programs for pregnant and postpartum women. (Page 610).

Action Taken or to be Taken

CSAT is working with the Center Point Program to apply for funding under the Targeted Capacity Expansion Program. The San Francisco Department of Public Health's Treatment on Demand program will receive FY 2000 support for treatment services under the Targeted Capacity Expansion Program. The remaining funds will be devoted to evaluation efforts that are of interest to San Francisco around the issue of substance abuse. Finally, of the resources provided for residential treatment programs for women, CSAT will fund the single continuation award that remains. The remaining $4.4 million will be established as a subactivity under the Targeted Capacity Expansion Program for 5-6 new awards.

Item: Treatment for adolescent drug abusers -- Recent reports by NIH and the Institute of Medicine recommend expansion of effective treatment approaches for adolescent drug abusers. CSAT is to be commended for its work in developing and testing manuals for program interventions through the Cannabis Youth Treatment initiative. CSAT is encouraged to expand this initiative by examining the immediate and long-term outcomes across the developmental period when adolescents are at risk for peak drug use, and by taking steps to replicate and improve such treatment approaches. (Page 610).

Action Taken or to be Taken

In FY 1998, CSAT funded five grants under the Adolescent Treatment Models Program and another six awards were made in FY 1999. It is expected that all eleven programs will continue in FY 2000. This program is designed to identify treatment models for adolescents which have demonstrated cost effectiveness and highly successful client outcomes and replicate these models. These grants will result in manuals to guide implementation and replication of the most effective models, providing best practices to the field and enhancing the effectiveness of treatment for the nation's youth.

Item: Rock Island County Council on Addictions (RICCA) – Within the total provided... $350,000 is for the Rock Island County Council on Addiction's (RICCA) Healthy Youth Drug Prevention Program in Rock Island, Illinois. (Page 611).

Action Taken or to be Taken

CSAP is working with this organization to develop a program plan. Assuming that grant requirements are met, the program will be able to receive support in FY 2000.

Item: Gambling research -- The Senate recently heard testimony about pathological gambling disorders and the importance of additional federal research in this area as recommended by the National Gambling Impact Study Commission. The Center is urged to conduct demonstration projects to determine effective strategies and best practices for preventing and treating pathological gambling. (Page 611)

Action Taken or to be Taken

CMHS is planning a series of activities to examine effective strategies to address pathological gambling with a focus on the analysis of the prevalence and identification of such problems, the effectiveness of prevention and treatment strategies, and the implications for public education, policy making, and professional training.

Substance Abuse and Mental Health Services Administration
Authorizing Legislation

	FY 2000 Amount Authorized	FY 2000 Appropriation	FY 2001 Amount Authorized	FY 2001 Estimate
Knowledge Development and Application:				
PHSA Section 501.....	Indefinite	$296,675,000	Indefinite	$282,156,000
Targeted Capacity Expansion:				
PHSA Section 501.....	Indefinite	$194,590,000	Indefinite	$278,368,000
High Risk Youth:				
PHSA Section 501.....	Indefinite	$7,000,000	Indefinite	$7,000,000
Mental Health:				
a. HIV/AIDS Demonstrations:				
PHSA Section 520 B (j).....	Expired	---	Expired	---
b. Clinical Training and AIDS Training:				
PHSA Section 303.....	Indefinite	---	Indefinite	---
Substance Abuse Prevention:				
a. High Risk Youth:				
PHSA Section 517 (h).....	Expired	---	Expired	---
b. Community Prevention:				
PHSA Section 516 (c).....	Expired	---	Expired	---
c. Public Education and Dissemination:				
PHSA Section 515 (c).....	Indefinite	---	Indefinite	---
d. Clinical Training:				
PHSA Section 515 (c).....	Indefinite	---	Indefinite	---
Substance Abuse Treatment:				
a. Residential Treatment Programs for Pregnant and Postpartum Women:				
PHSA Section 508 (r).....	Expired	---	Expired	---
b. Demonstration Projects of National Significance:				
PHSA Section 510 (e).....	Expired	---	Expired	---
d. Grants for SAT in Criminal Justice				
PHSA Section 511 (d).....	Expired	---	Expired	---
e. Training in Provision of Treatment				
PHSA 512 (d).....	Expired	---	Expired	---

Substance Abuse and Mental Health Services Administration
Authorizing Legislation
(continued)

	FY 2000 Amount Authorized	FY 2000 Appropriation	FY 2001 Amount Authorized	FY 2001 Estimate
Unfunded Substance Abuse Activities:				
a. Workplace & Small Business (Prevention): PHSA Section 518 (e).....	Expired	---	Expired	---
b. Outpatient Treatment Programs for Pregnant and Postpartum Women: PHSA Section 509 (a).....	Expired	---	Expired	---
Mental Health Services for Children: PHSA Section 565	Expired	$82,763,000	Expired	$86,763,000
Protection and Advocacy: P.L. 102-173, Section 117.....	Expired	24,903,000	Expired	25,903,000
PATH Formula (Homeless): PHSA Section 535 (a).....	Expired	30,883,000	Expired	35,883,000
Mental Health Block Grant: PHSA Section 1920 (a).....	Expired	356,000,000	Expired	416,000,000
Substance Abuse Block Grant: a. Block Grants for Prevention and Treatment of Substance Abuse: PHSA Section 1935 (a).....	Expired	1,600,000,000	Expired	1,631,000,000
Program Mangement: a. Program Management - PHSA Section 301; Section 501	Indefinite	57,554,000	Indefinite	58,443,000
b. SEH Workers' Comp. Fund - P.L. 98-621.....	Indefinite	1,500,000	Indefinite	1,500,000
Total, SAMHSA.....		**$2,651,868,000**		**$2,823,016,000**
Total Program Level.....		**$2,651,868,000**		**$2,823,016,000**
Total Appropriations Against definite authorizations.....		---		---

Substance Abuse and Mental Health Services Administration
Appropriations History

	Budget Estimate to Congress		House Allowance		Senate Allowance		Appropriation	
Alcohol, Drug Abuse, and Mental Health Administration								
1989	$1,504,413,000		$507,594,000	2/	$1,583,191,000		$1,562,712,000	
1989 Supplmntl	—		---		---		283,000,000	
1990	1,738,716,000		1,917,162,000		2,005,448,000		1,926,818,000	3/
1990 Sec 518 Red.	---		---		---		-1,135,000	
1990 (DOT Appr)	300,000,000		---		---		727,000,000	
1990 Sequester	---		---		---		-26,745,000	
1991	2,831,511,000	4/	2,825,891,000	3/5/	3,000,283,000	3/	2,966,898,000	3/
1991 Sec 514 Red.	---		---		---		-77,039,000	
1991 Sequester	---		---		---		-38,000	
1992	3,048,328,000	6/	2,917,742,000	6/	3,175,832,000		3,081,119,000	7/
1992 Sec 513, Sec 214 Red.	---		---		---		-8,389,000	
1993	3,241,159,000	8/	3,099,902,000	8/	n.a.		n.a.	
Substance Abuse and Mental Health Services Administration								
1993 9/	2,037,928,000	8/	1,942,417,000	8/	2,049,609,000	8/	2,023,524,000	10/
1993 Sec 216, 511, 513 Red.	---		---		---		-18,721,000	
1994	2,153,480,000	11/	2,057,167,000		2,119,205,000	12/	2,125,178,000	13/
1995	2,365,874,000	14/	2,166,148,000		2,164,179,000	15/	2,181,407,000	16/
1995 Red. P.L.103-333	---		---		---		-33,000	
1995 Red. P.L. 103-133	---		---		---		-44,000	
1995 Resc. P.L. 104-19	---		---		---		-662,000	
1996	2,244,392,000		1,788,946,000		1,800,469,000	17/	1,854,437,000	18/
1997	2,098,011,000		1,849,946,000		1,873,943,000		2,134,743,000	
1997 Red.P.L. 104-208	---		---		---		-362,001	
1997 Red. P.L. 104-208	---		---		---		-69,000	
1997 Advance Appro. P.L.104-121			---		---		+50,000,000	19/

Substance Abuse and Mental Health Services Administration
Appropriations History (Continued)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1998	$2,155,943,000	$2,151,943,000	$2,126,643,000	$2,146,743,000
1998 Advance Appro. P.L. 104-121		---	---	+50,000,000 19/
1999	2,279,643,000	2,458,005,000	2,151,643,000	2,488,005,000
2000	2,626,505,000	2,413,731,000	2,750,700,000	2,654,953,000
2000P.L.106-11				-3,085,000 20/
2001	2,823,016,000			

FOOTNOTES:

2/ House did not consider the NIDA and NIAAA research, research training, and direct operation, demonstration programs, Protection and Advocacy, and Grants to States, as they lacked authorizing legislation.
3/ Excludes advance funding for Homeless.
4/ Includes $7,359,000 in 1991 Advance Funding for Homeless.
5/ House did not consider research training Community Support program; and mental health prevention demonstrations program as it lacked authorizing legislation.
6/ Excludes $31,000,000 proposed to be transferred from the Office of National Drug Control Policy (ONDCP) Special Forfeiture Fund.
7/ Excludes $19,000,000 transferred from the Special Forfeiture Fund.
8/ Excludes $34,701,000 proposed to be transferred from the ONDCP Special Forfeiture Fund.
9/ FY 1993 Budget Estimate to Congress and House Allowance represent comparable funding levels based on the 1992 ADAMHA Reorganization Act as identified in Conference Report.
10/ Excludes $33,701,000 transferred from the ONDCP Special Forfeiture Fund.
11/ Includes $115,000,000 Presidential Investment.
12/ Excludes $35,000,000 proposed to be transferred from the ONDCP Special Forfeiture Fund.
13/ Excludes $25,000,000 transferred from the ONDCP Special Forfeiture Fund.
14/ Excludes $45,000,000 proposed to be transferred from the ONDCP Special Forfeiture Fund.
15/ Excludes $25,000,000 proposed to be transferred from the ONDCP Special Forfeiture Fund.
16/ Excludes $14,000,000 proposed to be transferred from the ONDCP Special Forfeiture Fund. Reflects $44,000 in SLUC and $33,000 in performance awards reductions mandated by the appropriation bill and a rescission in the amount of $662,000.
17/ Includes $200,000,000 proposed transfer from the Safe and Drug Free Schools Act program of the Dept of Education for youth substance abuse prevention programs in schools and communities.
18/ A regular 1996 appropriation for this amount was not enacted.
19/ Advance appropriation P.L. 104-121 from Social Security Administration to Substance Abuse Block Grant.
20/ Reflects a recission mandated by P.L.106-113.

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SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
General Statement/Overview
(dollars in thousands)

	FY 1999 Actual	FY 2000 Pre-rescission Appropriation	FY 2000 Final Appropriation	FY 2001 Estimate	Increase/ Decrease
Knowledge Development and Application	**$289,307**	**$299,263**	**$296,675**	**$282,156**	**-$14,519**
Mental Health (Non-add)	*(96,419)*	*(138,982)*	*(136,875)*	*(136,875)*	*(—)*
SA Prevention (Non-add)	*(77,591)*	*(60,022)*	*(59,541)*	*(50,022)*	*(-9,519)*
SA Treatment (Non-add)	*(115,297)*	*(100,259)*	*(100,259)*	*(95,259)*	*(-5,000)*
Targeted Capacity Expansion	**133,307**	**194,590**	**194,590**	**278,368**	**+83,778**
Mental Health (Non-add)	*—*	*—*	*—*	*(30,000)*	*(+30,000)*
SA Prevention (Non-add)	*(78,218)*	*(80,283)*	*(80,283)*	*(85,207)*	*(+4,924)*
SA Treatment (Non-add)	*(55,089)*	*(114,307)*	*(114,307)*	*(163,161)*	*(+48,854)*
High Risk Youth	**6,991**	**7,000**	**7,000**	**7,000**	**—**
Children's Mental Health Services	**77,909**	**83,000**	**82,763**	**86,763**	**+4,000**
MH Protection & Advocacy	**22,949**	**25,000**	**24,903**	**25,903**	**+1,000**
PATH Homeless Formula Grants	**25,991**	**31,000**	**30,883**	**35,883**	**+5,000**
Mental Health Block Grant	**288,816**	**356,000**	**356,000**	**416,000**	**+60,000**
Substance Abuse Block Grant	**1,585,000**	**1,600,000**	**1,600,000**	**1,631,000**	**+31,000**
Program Management	**56,517**	**59,100**	**59,054**	**59,943**	**+889**
Total, SAMHSA	**$2,486,787**	**$2,654,953**	**$2,651,868**	**$2,823,016**	**+$171,148**
FTEs	561	614	614	614	---

AGENCY OVERVIEW

SAMHSA's fiscal year 2001 budget request is responsive to the Nation's recent attention to behavioral health concerns and their impact on service quality and availability. There is increasing recognition that mental health and substance abuse services should be available on the same basis as primary health care. The recently-released Surgeon General's Report on Mental Health calls attention to the many Americans unable to access high quality mental health care because of stigma, lack of insurance coverage, and lack of service availability There is also an increasing body of knowledge demonstrating that prevention programs, interventions and treatment are effective. The federal government must provide leadership in ensuring the availability, accessibility, and quality of behavioral health care services, in particular, age appropriate interventions for children and young adults. The time is right for the Nation to invest in high quality mental health and substance abuse services delivered as part of integrated, comprehensive systems.

The FY 2001 budget request of $2.8 billion is responsive to these and other national concerns. It reflects an increase of $171.1 million, or 6.5 percent, over the FY 2000 appropriation. SAMHSA's budget proposal approaches problems of service quality and accessibility in the context of systems of care, rather than in an isolated manner. Many of the initiatives involve both mental health and substance abuse; both

prevention and treatment; both health care and social service systems; or SAMHSA working closely with other federal agencies with relevant missions. Initiatives will integrate mental health and substance abuse into health and social service systems and fill gaps in the patchwork of programs which already exist. New initiatives have been selectively chosen to address SAMHSA's four GPRA goals:

- Goal 1. Assure service availability: Growth in the Block Grant and formula grant programs will work to improve local service systems, and to continue to make progress in closing nationwide service gaps.

- Goal 2. Meet unmet and emerging needs: Growth in Targeted Capacity Expansion programs will address new and emerging service issues, such as local mental health needs, the bicoastal increase in heroin abuse seen recently, and HIV/AIDS problems in minority and elderly populations; to meet community service needs of priority populations such as children and the homeless; and to continue to make progress in closing nationwide service gaps.

- Goal 3. Bridge the gap between knowledge and practice: New and highly relevant service information will continue to be developed in such areas as youth violence and prevention programming. Systems will be established to employ electronic communication methods permitting practitioners to select among proven prevention techniques, and to support community action in adopting practices they deem to be the best for their particular circumstances.

- Goal 4. Enhance data to inform policy, allocate resources, and ensure accountability: Sufficient resources will be devoted to national and program-specific data collection systems to indicate progress and identify where service system deficiencies exist, and to monitor treatment outcomes.

Prevention and early intervention of mental health and substance abuse problems among children and adolescents, revitalization of our local mental health systems, expanded availability of children's mental health services, targeted capacity expansion, school violence, and programs for high risk youth, are all initiatives which are designed to identify early at risk individuals and develop the interventions necessary to prevent serious addictive and mental disorders. For example, Americans have all been struck by recent instances of youth violence. Every school in this country is taking steps to try to prevent similar acts of violence in their own communities. There is no magic answer–there is no simple solution. The urgency of the issues that SAMHSA will address calls for dramatic change and a serious commitment to the issues of mental health prevention, substance abuse and our Nation's children. The FY 2001 request represents a careful consideration of where and how federal intervention will be most effective in improving service delivery systems.

UTILIZING BEST PRACTICE RESULTS

A key aspect of SAMHSA's mission is to provide national leadership in ensuring that knowledge based on sound science and best practices is used effectively in the provision of addictive and mental health services. The Agency has made substantial progress in this regard. The FY 2001 Justification highlights several recent and important accomplishments, and explains how knowledge developed about these best

practices is being translated into improved service delivery. As an example, knowledge about effective substance abuse prevention programs has reached the point where the Center for Substance Abuse Prevention (CSAP) now requires all High Risk Youth and State Incentive Grant projects to employ only prevention practices proven to be effective. They are identified through such communication mechanisms as the National Registry of Effective Prevention Programs, and the Prevention Decision Support System currently being developed. This represents a substantial advance in service programming over that of just a few years ago.

Accomplishments identified throughout the budget narrative focus on the knowledge development aspects of SAMHSA programs. However, the Agency has also made considerable progress in applying new and creative techniques in communicating information to the public. The ongoing Girl Power! Campaign represents an excellent example. Through a combination of community education kits, activity books developed with the Girl Scouts of the U.S.A., audiovisual material, and an interactive Website, SAMHSA has reached millions of 9-14 year old girls and their parents with effective prevention messages. The number of Website hits alone increased from about 170,000 in early 1998 to over 1.6 million last October. Feedback on the program has been exceptional; notable are receipt of an Aesculapius Award of Excellence and the American Library Association including this program in their list of 50 Great Websites. The combination of relevant knowledge development and highly effective knowledge application has resulted in improved behavioral health service quality throughout the Nation.

MAJOR MENTAL HEALTH SERVICE EXPANSION

Over the past 50 years, the mental health system in America has changed from institutional care to a community-based system of care. While there have been major advances in medicines and scientific knowledge about the human brain over this period, progress in the service delivery system has been mixed, and services in some communities are woefully inadequate. It is now time for a revitalization of the current mental health system. Our goal is to advance toward a mentally healthy America in the year 2010, where children will be valued, nurtured and protected; adults will have a productive workplace, strong families and healthy lifestyles; and elders will be secure, supported and respected. The increase requested for mental health for FY 2001 is $100 million, an increase of nearly 16 percent over the FY 2000 appropriation. Mental health increases have been accorded the highest priority for expansion in FY 2001.

The last time the federal government highlighted the mental health needs of the country was during the late 1970's, when nationwide implementation of the Community Mental Health Systems Act was a major goal of the federal government. Since then progress in establishing systems of community mental health care and establishing key linkages with primary health care and other systems has been uneven at best. As a result of increasingly limited resources, public service systems have focused on treatment of adults with serious mental illnesses; health care insurance coverage has declined. There has been little emphasis on prevention and early intervention services for the population as a whole, and insufficient emphasis on health services for at risk populations, including the homeless. The variety of providers and multiple funding sources has resulted in patched together “systems” leaving huge gaps in mental health care.

Yet mental health problems have not abated over the years. According to the Surgeon General's report, only about half the individuals with mental illness currently receive any treatment. Mentally ill children, older adults, those with co-occurring substance abuse, and those without health insurance often receive little or no care. Stigma remains a serious and difficult issue. Yet federal investments in research and Knowledge Development and Application (KDA) studies are continually finding more effective ways to prevent serious problems and provide more effective community-based services. SAMHSA's challenge is to ensure that this knowledge finds its way into our communities.

Reinvigorating the mental health service system nationwide is the centerpiece of SAMHSA's FY 2001 budget request. The proposal includes the initiation of a new Mental Health Targeted Capacity Expansion (TCE) program focused on the gaps and deficiencies in the present system of care. In its broader context, the Initiative also includes continuing the program begun in 1999 to combat youth violence; reducing racial and ethnic disparities in the provision of mental health services; and expanding State systems of community-based care.

The new Center for Mental Health Services (CMHS) Targeted Capacity Expansion program, proposed to be established at the $30 million level, will consist of two major elements:

- Expanding local prevention and early intervention services. The intention is to integrate these services throughout the community, in educational, employment, primary care, justice, and similar settings, with a particular emphasis on children at a young age. "Systems" needs to be created where now they are weak or non-existent.

- Addressing gaps in community mental health care. The causes may vary, but it is clear that significant gaps persist in the provision of mental health treatment. They may be racial, gender, socioeconomic, or geographic in nature, or affect specific populations such as children, homeless, or the elderly. As in the substance abuse Targeted Capacity Expansion programs, the goal will be to identify serious system deficiencies and fill these gaps with proven effective, culturally appropriate systems of care. Federal support will be time-limited in nature but structured to ensure long-term viability. TCE sites will put in place quality and measurement systems not only to assess achievement of this program's goals, but to demonstrate how effective use of these concepts ultimately improves client outcomes.

Even when well-coordinated, a community-based approach such as this is not in itself sufficient to revitalize and reinvigorate all aspects of mental health service delivery in the public sector. State-run service programs, services for the homeless, and children's service programs are critical to developing a "no wrong door" approach for those needing services. Increases being proposed in other CMHS programs will expand mental health care coverage throughout all the States, and in the many communities not reached through the new Targeted Capacity Expansion program.

Deserving of note in this regard is continuation of $78 million in funding for the Youth Violence Prevention program jointly supported with the Departments of Education and Justice. Early identification of youth at risk for developing severe emotional problems and increasing the availability of appropriate prevention and

intervention services for them within a community setting is a good example of pressing community mental health needs. CMHS' program efforts will be well coordinated on a national as well as State level to ensure they are working together to achieve the desired results.

ADDRESSING GAPS IN SUBSTANCE ABUSE SERVICES

Momentum must also be continued in FY 2001 to reduce substance abuse problems in the Nation, both through effective prevention and through expanded treatment. The request proposes a total substance abuse budget of $2 billion in FY 2001. Approximately 16,000 more individuals will be treated with SAMHSA resources, for a total of approximately 414,000 persons that will be provided substance abuse treatment services.

Growth in the Center for Substance Abuse Treatment (CSAT) Targeted Capacity Expansion program (+$48.8 million) will focus on vulnerable populations which include minority communities, the homeless, women, individuals with dual diagnosis, and youth. As part of a "Strengthening Communities" initiative, an effective range of services will be targeted to certain geographic areas, including rural areas, small towns, and metropolitan areas experiencing particularly acute substance abuse problems. Appropriate linkages will be made with Empowerment Zones. The program will continue to be responsive to emerging drug trends, notably those identified in State-level data which will be available from the National Household Survey on Drug Abuse. Programs in all areas will be based on sound, scientifically-based evidence of effectiveness.

An increase of $31 million, or about 2 percent, is requested for the Substance Abuse Prevention and Treatment (SAPT) Block Grant. The Block Grant continues to serve as SAMHSA's primary mechanism for supporting public prevention and treatment programs throughout the Nation. These resources will help States maintain service capacity while continuing work to target services effectively and develop data systems to report on service outcomes. Block Grant set-aside funds are also employed to help States manage these resources effectively.

While attention has in the past been focused on drug treatment gaps, serious gaps exist in the provision of prevention services as well. A balanced community health system must include a commitment of funds to strengthen prevention and health promotion programs proven to be effective in reducing the prevalence of substance abuse, especially among children and youth. The CSAP State Incentive Grant program has shown great promise in closing these gaps through a systems approach to service availability. An additional $5 million is requested to ensure that most States have received an Incentive Grant award by FY 2001. The program will be restructured in order to be well positioned to address State needs identified in the 1999 Household Survey results available later this year.

The expansion of the Household Survey will in fact become an extremely important indicator of regional substance abuse prevalence in FY 2000. The 1999 Survey is for the first time beginning to collect State-level data on substance abuse, including tobacco use. The Household Survey results comprise the most important indicator of the extent of substance abuse available in the country. Moreover, it is the best

predictor of future trends. The first report of State-level data from 1999 will become available in the fall of 2000.

In direct support of SAMHSA's service initiatives are two new activities, a Prevention Decision Support System (PDSS) and a National Treatment Outcome Monitoring System (NTOMS). The CSAP PDSS system will, through Internet linkages, provide prevention practitioners with immediate access to prevention information and best practices. This sophisticated system will help them select scientifically sound prevention approaches which fit their local needs. Preliminary work will continue on this system in FY 2001. The CSAT NTOMS system will be designed as a sample-based network to provide continual feedback information on drug treatment outcomes, and to identify program-level determinants of changes. These systems are indicative of SAMHSA's continuing commitment to developing more sophisticated systems of information collection, analysis and utilization. No data system currently funded by any entity provides this type of capacity which is essential to support the goals of the National Drug Control Strategy.

REACHING VULNERABLE POPULATIONS AND REDUCING STIGMA

In addition to the larger initiatives, the FY 2001 request includes several new activities focusing on issues of concern to both the mental health and substance abuse fields. They will not be addressed in isolation, but rather, projects in these areas will also be linked to the major service initiatives. Three are highlighted briefly below.

- Reducing Racial and Ethnic Disparities ($5 million):

  The budget request will support the identification of new ways to improve the quality of and access to mental health care among ethnic minority populations. The effort is part of the newly proposed TCE program for mental health and will include a rigorous evaluation of quality of care as it affects treatment outcomes for these populations.

- The Homeless Population (+$5 million): Another priority indicated by mental health and substance abuse professionals is the expansion of community support services to individuals who are homeless or at risk of homelessness, including homeless families in the PATH program. The FY 2001 request increases the PATH program by over 16 percent, providing mental health and ancillary services for about 6,000 more clients. Two-thirds of the clients served through this program also have a co-occurring substance abuse disorder.

- Recovery Community Support/Anti-Stigma ($4 million):

  The FY 2001 request continues the effort to increase public understanding about consumers of substance abuse treatment services. This KDA program promotes family support groups and other recovery organizations, facilitates the transition from treatment, and improves public perception about individuals in recovery.

Rarely are these or other SAMHSA initiatives undertaken outside the context of other services systems, be they emergency response, child welfare, or educational in nature. In all of its service initiatives, SAMHSA will leverage external resources to ensure a maximum commitment of resources at minimal cost to the Agency.

To effectively manage these programs and the incredibly diverse range of issues which confront the Agency, two critical resources are necessary: accurate and timely data, and sufficient management resources. Much of SAMHSA's data collection effort is program-specific, and is budgeted as an integral part of the program requests previously described. National data serves a variety of purposes, as indicated by SAMHSA's recently announced Substance Abuse Treatment Facility Locator. This internet-based service provides people seeking help, family doctors, substance abuse counselors, and others with the locations, phone numbers, service array, and road maps to the nearest treatment facilities. Information for the locator derives from SAMHSA's annual Uniform Facility Data Set survey.

The FY 2001 budget requests a total staffing level of approximately 614 FTEs through the addition of $0.9 million for increased pay costs. Some relief from SAMHSA's acute staffing shortage was provided in the 2000 appropriation. Additional staff have been deployed to communicate best practices; provide hands-on technical assistance; address policy issues ranging from patient confidentiality to drug testing to parity in health care coverage; coordinate activities with numerous other federal agencies; and remain sufficiently abreast of trends and policy changes to assure continued federal leadership in the field.

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B. CENTER FOR MENTAL HEALTH SERVICES
Overview

	1999 Actual	2000 Pre-rescission Appropriation	2000 Final Appropriation	2001 Estimate	Increase or Decrease
BA	$512,084,000	$633,982,000	$631,424,000	$731,424,000	+ $100,000,000

The Center for Mental Health Services (CMHS) supports the delivery of comprehensive mental health services designed to improve quality and access to care for all Americans. Through its programs, CMHS promotes the development of effective, community-based services to some of the most vulnerable people in the nation. These include children and adolescents with serious emotional disturbances, adults with serious mental illnesses, homeless families affected by mental illness, and people with co-occurring mental illness and HIV/AIDS or chemical dependencies.

The Administration has focused national attention on improving services for people with mental illness and promoting the nation's mental health through three very significant activities in 1999: the first White House Conference on Mental Health, the Surgeon General's Call to Action to Prevent Suicide, and the first Surgeon General's Report on Mental Health. These activities showcased the significant scientific and clinical advances that have been made in the treatment of mental illnesses and the tremendous distance still to go to make effective, affordable services available for all Americans. The U.S. Surgeon General stated in his Report on Mental Health, "*concerns regarding mental illness and mental health too often were relegated to the rear of our national consciousness... We have allowed stigma and a now unwarranted sense of hopelessness about the opportunities for recovery from mental illness to erect these barriers. It is time to take them down*."

More than 63 million Americans experience some type of mental health problem. This exacts a devastating economic, social, and physical toll on individuals of all ages, their families, and their communities. Of these Americans, 6.7 million (including 1.1 million children and adolescents) are disabled by severe and persistent mental illnesses. In the United States, mental illness is the second leading cause of disability and premature mortality. In a landmark study conducted by the World Bank and the World Health Organization (WHO), mental illnesses represent 5 of the 10 leading causes of disability worldwide. No one is immune to the risk of mental illness by virtue of race or ethnicity, education, age, socioeconomic status, or gender. The costs per year of mental illnesses to this Nation in health care dollars spent and productivity lost are over $150 billion. Mental health problems take a staggering social cost that affect Americans' employment, physical health, housing, and the overall quality of life for them and their families.

Despite the advances in our knowledge of effective community based mental health interventions that were summarized in the Surgeon General's report, critical gaps still exist between those who need service and those who receive service. Less than two-thirds of adults with severe mental illnesses receive treatment for their illnesses, and estimates of the proportion of children and adolescents with serious emotional disturbances who receive mental health care for their problems are as low as one in five.

The nation's mental health service system is complex, and services are fragmented. Often, people needing mental health services come into contact with primary health care providers, welfare, schools, or the criminal justice system. Too often, these systems are unprepared and unable to recognize mental health problems and provide appropriate, effective care. Too often, yawning gaps in services and service funding prevent early identification and effective treatment of mental illnesses. Particularly vulnerable are people who have complex economic, social, and health problems, and who require help with medications, housing, welfare, education, and other categorical services. Women, children, the elderly, ethnic minorities, the homeless, persons with co-occurring substance abuse disorders, people who experience disasters, individuals with HIV/AIDS, and those involved in the criminal justice system are all groups that are particularly in need of specialized mental health services. In the last year, youth violence and youth suicide have gained national attention.

CMHS' proposals for fiscal year 2001 are designed to build the knowledge base and service system infrastructure so that people with mental illnesses can get effective treatment, and these illnesses and the disabilities associated with them can be prevented and recovery from them hastened. CMHS' FY 2001 initiatives build on the four SAMHSA GPRA goals:

- Assure services availability
- Meet unmet and emerging needs
- Bridge the gap between knowledge and practice
- Strengthen data collection to improve quality and enhance accountability

FY 2001 Agenda

In FY 2001, SAMHSA's Center for Mental Health Services budget request is $731 million, an increase of $100 million over the FY 2000 appropriation. This amount will enhance existing mental health services program through the Community Mental Health Services (CMHS) Block Grant, Targeted Capacity Expansion, PATH, Protection and Advocacy and the Children's Mental Health Services Program. Expansion of these programs will increase services availability and meet emerging, unmet needs. The FY 2001 budget will help bridge the gap between knowledge and practice by strengthening CMHS' Knowledge Development and Application (KDA) programs, and promote accountability and quality improvement through improved mental health data collection. As the Surgeon General's Report affirms: "mental health is fundamental to health." These initiatives represent a sound investment to assure America has a healthy future.

KDA PROGRAM ACCOMPLISHMENT

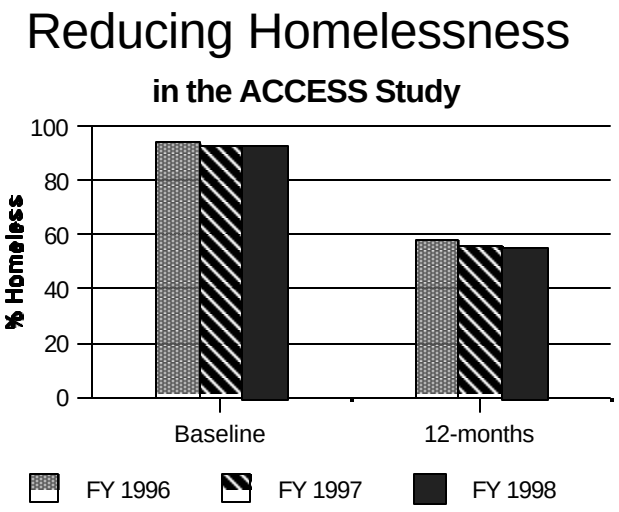
Program: The Access to Community Care and Effective Services and Supports (ACCESS) Program

Goal: The ACCESS Program is an innovative interdepartmental effort that is testing the impact of systems integration on outcomes for homeless people with mental illnesses.

Findings:

- ACCESS projects are successful at getting people off the streets and helping them stay in housing. Within the first three months of enrollment, homeless mentally ill participants showed a 47% reduction in the number of days homeless. After 12 months, the number of days had reduced by 76%.

- ACCESS consumers show significant clinical improvements. After 12 months of services, homeless mentally ill participants showed: a 54% *decrease* in minor criminal activity; a 44% *decrease* in self-reported victimization; a 34% *decrease* in total days of drug use; a 35% *decrease* in psychotic symptoms; a 43% *decrease* in depressive symptoms; and a 33% *increase* in the number of days worked**.**



Application:
Homeless persons with mental illness do respond to outreach and are willing to be engaged into services. CMHS is testing whether similar strategies will be effective with homeless families. Results are being shared with State mental health agencies, homeless service providers, and HUD, among

others. Manuals and models on available through CMHS World Wide Web site and from the Knowledge Exchange Network (KEN).

KDA PROGRAM ACCOMPLISHMENT

Program: Employment Intervention Demonstration Program (EIDP)

Goal: To identify the most effective approaches for assisting adults with serious mental illness to find and maintain competitive employment.

Findings: Preliminary data from the first 3 years show:

Proportion of EIDP Participants Employed:

- 28% of those receiving services for 3 months
- 40% of those receiving services for 6 months
- 47% of those receiving services for 9 months
- 51% of those receiving services for 12 months
- 56% of those receiving services for 18 months

(Compare to: The 1994/95 employment rate for persons with severe disabilities was 26%.)

Productivity Potential:

- EIDP clients worked 793,577 hours and earned $4.2 million in the first 3 years of the project.
- 2234 jobs were held by clients in the first 3 years, an average of 2.3 jobs per worker.

Job Features:

- Jobs held by clients paid an average of $6.03 per hour.
- 82% of jobs were part-time; jobs averaged 22 hours per week.

Application:

Given the right support services, people with psychiatric disabilities can work. Results from this KDA program have been shared with all of the State mental health agencies and State mental health planning councils. States will be expected to incorporate employment readiness programs in their CMHS block grant applications and in their implementation plans.

Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
Mechanism Table
(Dollars in Thousands)

	FY 1999 Actual		FY 2000 Pre-Recission Appropriation		FY 2000 Final Appropriation		FY 2001 Estimate	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
KNOWLEDGE DEVELOPMENT & APPLICATION (KDA)								
Grants/Cooperative Agreements:								
Continuations	142	31,775	181	39,118	181	39,118	105	38,621
Renewal	4	871	7	2,590	7	2,590	5	2,450
New	89	18,938	101	20,250	101	19,930	162	24,497
Supplements	(30)	2,293	(9)	3,930	(9)	3,930	---	---
Subtotal, Grants/Cooperative Agreements	235	53,877	289	65,888	289	65,568	272	65,568
Contracts	35	41,878	30	72,427	30	70,640	30	70,640
Technical Assistance	---	97	---	97	---	97	---	97
Review Cost	1	567	1	570	1	570	1	570
TOTAL, KDA	**271**	**96,419**	**320**	**138,982**	**320**	**136,875**	**303**	**136,875**
TARGETED CAPACITY EXPANSION (TCE)								
Grants/Cooperative Agreements:								
Continuations	---	---	---	---	---	---	---	---
Renewal	---	---	---	---	---	---	---	---
New	---	---	---	---	---	---	69	28,750
Supplements	---	---	---	---	---	---	---	---
Subtotal, Grants/Cooperative Agreements	---	---	---	---	---	---	69	28,750
Contracts	---	---	---	---	---	---	2	750
Technical Assistance	---	---	---	---	---	---	---	---
Review Cost	---	---	---	---	---	---	1	500
TOTAL, TCE	---	---	---	---	---	---	**72**	**30,000**
CHILDREN'S MENTAL HEALTH								
Grants/Cooperative Agreements:								
Continuations	24	31,631	45	60,536	45	60,299	47	61,299
Renewal	---	---	---	---	---	---	---	---
New	22	20,618	2	2,000	2	2,000	5	5,000
Supplements	(22)	5,196	---	---	---	---	---	---
Subtotal, Grants/Cooperative Agreements	46	57,445	47	62,536	47	62,299	52	66,299
Contracts	14	19,862	15	20,286	15	20,286	15	20,286
Technical Assistance	---	124	---	178	---	178	---	178
Review Cost	1	478	---	---	---	---	---	---
TOTAL, CHILDREN'S	**61**	**77,909**	**62**	**83,000**	**62**	**82,763**	**67**	**86,763**
PROTECTION AND ADVOCACY	**56**	**22,949**	**56**	**25,000**	**56**	**24,903**	**56**	**25,903**
MENTAL HEALTH BLOCK GRANT	**59**	**288,816**	**59**	**356,000**	**59**	**356,000**	**59**	**416,000**
PATH	**56**	**25,991**	**56**	**31,000**	**56**	**30,883**	**56**	**35,883**
TOTAL, CMHS	***503***	***512,084***	***553***	***633,982***	***553***	***631,424***	***613***	***731,424***

B. CENTER FOR MENTAL HEALTH SERVICES
1. Knowledge Development and Application (KDA) Program

Authorizing Legislation - Section 501 of the Public Health Service Act.

	1999 Actual	2000 Pre-rescission Appropriation	2000 Final Appropriation	2001 Estimate	Increase or Decrease
BA....	$96,419,000	$138,982,000	$136,875,0000	$136,875,000	---

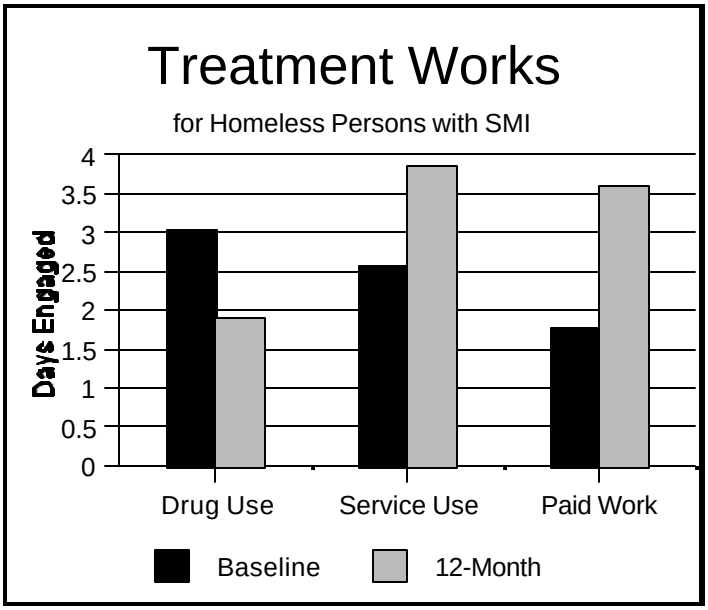
2001 Authorization

PHSA Section 501 . . . . . Expired

Purpose and Method of Operation

The Knowledge Development and Application (KDA) program promotes the continuous improvement of service delivery systems for children and adults with serious mental health problems. The KDA program includes three major areas of activity: 1) knowledge development activities that identify the most effective service delivery practices; 2) knowledge synthesis activities that translate program findings into useful products for the field; and 3) knowledge application projects that support adoption of exemplary service approaches throughout the country. Through CMHS' KDA programs, new interventions are evaluated. Promising programs are refined through replication over a range of real-world settings. Findings are sifted for results that can be practically implemented in community programs. From the KDA knowledge base, CMHS helps States, communities, consumers, and others improve access to effective and affordable mental health services through the CMHS block grant, formula grant, and service delivery programs (e.g, Comprehensive Mental Health Services for Children with Serious Emotional Disturbance and their Families Program, the Projects for Assistance in Transition from Homelessness (PATH) Program, and the Mental Health Performance Partnership Block Grant Program). Fundamentally, the KDA Program is designed to promote improved service outcomes for all persons who experience mental health problems.

Since mental illness affects all ages, incomes, ethnic and racial groups, and genders, CMHS' KDA portfolio is broad. CMHS has ongoing KDA programs targeting children, adolescents and adults who have or who are at great risk of developing severe mental illnesses. CMHS KDA programs are already demonstrating important findings that CMHS is now helping States and communities adopt broadly. For example, CMHS' ACCESS KDA program has shown how homeless adults with severe mental illnesses and often, with co-occurring chemical dependencies, can be helped off the streets into stable housing. Twelve months after being enrolled into ACCESS mental health services, rates of homelessness at the 18 ACCESS sites dropped from an average of 93% to 56%, criminal activity was cut by 54%, psychotic symptoms were reduced by 35%, drug use dropped by 34%, and number of days worked increased by 33%. New CMHS KDA programs are trying to achieve similar results with homeless families that are affected by severe mental illness. Knowledge application projects are helping States and communities around the country to implement programs for homeless adults based on the models tested through ACCESS.



Similarly, evaluations of CMHS' comprehensive children's mental health KDA programs have pointed to significant improvements in the lives of children with serious emotional disturbances and families that can be achieved. For example, Sonoma County Youth & Family System of Care in California reduced by 30% the number of children with serious emotional disturbances who required out-of-home special education placements during 1998, while at the same time reducing average monthly Special Education placement costs by 40%. The Partnership Program in North Dakota reduced children's child's average length-of-stay in residential psychiatric placements by 55%, from 212 days before the program began, to 137 days. A third program, the PEN-PAL Project in North Carolina cut by 83% the number of children sent to psychiatric facilities. CMHS has set up nationwide training and technical assistance programs to help States redesign their children's mental health programs supported, in part, by the CMHS block grant to build on the results of these KDA findings.

Program Distribution of Funds
(dollars in thousands)

	FY 1999	FY 2000	FY 2001
Homeless	$10,324	$9,335	$9,335
HIV/AIDS	8,554	8,802	8,802
Adults	27,159	29,048	29,048
Children (non-School)	10,382	11,473	11,473
Youth Violence	40,000	78,217	78,217
Total, KDA	$96,419	$136,875	$136,875

Funding levels for the past five fiscal years were as follows:

	Funding	FTEs
1996.....	$ 38,032,000	—
1997.....	57,964,000	—
1998.....	57,964,000	—
1999.....	96,419,000	—
2000.....	136,875,000	—

Rationale for the Budget Request

The FY 2001 request includes level funding in the KDA program. CMHS will build on foundations already laid in previous years to:

- evaluate innovative service approaches,
- test promising interventions in real world conditions,
- get the results into the hands of State and local officials, community leaders, service providers, consumers and families, and
- improve access to effective, affordable mental health services, especially for vulnerable and under-served populations.

CMHS will intensify its KDA programs testing the effectiveness of prevention and treatment interventions for children and adults with severe and disabling mental illnesses, and for people with complex problems requiring coordinated or integrated services, e.g., adolescents and adults with mental illness who are involved with the criminal justice system, people with mental illness and co-occurring illnesses such as chemical dependency, HIV/AIDS, or other health problems. In FY 2001, for example, CMHS plans to implement the second phase of its Homeless Families KDA program ($2.45 million), extending to 8 additional communities, its study of the effectiveness of innovative interventions to prevent or shorten homelessness among families in which mental illness is a significant factor. The Center's $4.8 million in new HIV/AIDS KDA initiatives will focus on reaching front-line mental health service providers who serve

minority populations, and those for whom English is a second language, and people in rural areas, in order to provide them information about modifying high risk behavior and about the psychological and neuropsychological effects of HIV/AIDS that has been gained from previous CMHS HIV/AIDS KDA programs. A second HIV/AIDS KDA program will develop and test the effectiveness of brief HIV/AIDS prevention/intervention modules designed specifically for special populations of young adults and women, two groups in which the incidence of HIV infection continues to rise. The goals of this KDA program are to decrease high risk sexual behaviors, concurrent substance use and sexual activity, and the incidence of sexually transmitted diseases and pregnancy in the intervention populations.

For adults with severe and persistent mental illnesses, CMHS will intensify its Knowledge Application efforts to assist States and local communities to implement the Community Support Programs that earlier Knowledge Development programs have found to be effective. In FY 2001, CMHS will help States use the results from the Employment Intervention KDA Program to implement vocational programs for people with severe mental illness. Along the same lines, CMHS has demonstrated through its Criminal Justice Diversion Program that, for the many people entering the criminal justice system who have a serious mental illness and co-occurring substance abuse disorders, diversion programs into community treatment in lieu of incarceration or retention in jail can be highly effective. Already, numerous States, including Arizona, Connecticut, Maryland, Oregon, Pennsylvania, and Tennessee have implemented jail and prison diversion programs, reduced fragmentation of services, and created innovative Police Crisis Intervention Teams. In FY 2001, final results from the Criminal Justice Diversion KDA will be released, and intensive technical assistance and training will be provided to State and local jurisdictions to make necessary systems changes.

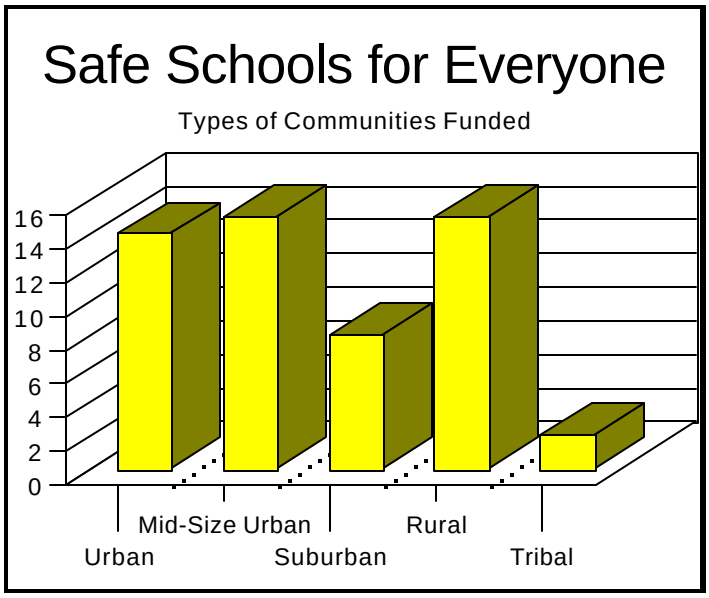
Continuing its long-standing practice, CMHS in FY 2001 will actively promote the involvement of consumers and families in every aspect of public mental health. New Knowledge application grants will be awarded to support consumer and family networks in the states ($3.6 million), and to provide technical assistance to existing consumer and family networks ($1.6 million).

Another of CMHS' knowledge application programs is the Knowledge Exchange Network (KEN). The goal of the program is to provide information about mental health via various media to users of mental health services, their families, the general public, policy makers, providers, and researchers. This is done through the distribution of publications and receipt of inquiries through the KEN website. The number of requests received is shown in the table below:

	1999 Estimate	2000 Estimate	2001 Estimate	Difference
Information requests	30,302	57,533	63,286	+5,753
Publications distributed	153,903	322,929	355,222	+32,293
Web site connections	197,659	400,370	440,407	+39,937

Funding for this program will continue in FY 2001.

The safety and well-being of the nation's children must be protected. Through CMHS' Safe Schools, Healthy Students (SS/HS) program, grants were made in 1999 to 54 school districts in 39 States. Each school district is implementing policies and mental health service programs to reduce the risk of youth violence. CMHS' School Action Grants support an additional 80 communities across the country to implement and evaluate programs designed to prevent violence and suicide, and promote mentally healthy development in their schools. In FY 2001, CMHS will work with its grantees and, through its knowledge application programs, with schools and communities across the country, to evaluate the youth violence and suicide prevention programs already in the field, and to disseminate findings from effective programs. In FY 1999, more than 450 school districts applied for SS/HS awards. Applicants painted a very disturbing picture of youth poverty, suicide, violence, hopelessness, and crime. CMHS was able to fund less than one-tenth of the applicants. The need for effective violence prevention, suicide prevention, and positive mental health promotion for children is great, requiring sustained commitment of resources and attention by all levels of government.



B. CENTER FOR MENTAL HEALTH SERVICES
2. Targeted Capacity Expansion

Authorizing Legislation - Section 501 of the Public Health Service Act.

	1999 Actual	2000 Pre-rescission Appropriation	2000 Final Appropriation	2001 Estimate	Increase or Decrease
BA	**$---**	**$---**	**$---**	**$30,000,000**	**+$30,000,000**

2001 Authorization
PHSA Section 501.....Expired

Purpose and Method of Operation

The proposed budget for Targeted Capacity Expansion (TCE) program constitutes a new discretionary program for the Center for Mental Health Services. However, the CMHS TCE program is modeled directly on the highly successful targeted capacity expansion programs of the Center for Substance Abuse Treatment and Center for Substance Abuse Prevention.

Targeted Capacity Expansion is a program designed to help meet emerging and urgent mental health service needs of local communities. Three-year grants will be made to cities, counties, and tribal governments to help them build the service system infrastructure necessary to address serious local or regional mental health problems. Prevention and treatment interventions proposed must have a strong evidence base and show commitment that resources will be committed to sustain the new TCE programs when the grant ends.

Funding levels for the past five fiscal years were as follows:

	Funding	FTEs
1996.....	$ —	—
1997.....	—	—
1998.....	—	—
1999.....	—	—
2000.....	—	—

Rationale for the Budget Request

The FY 2001 President's budget proposes $30,000,000 to implement a new Targeted Capacity Expansion program.. The proposed program addresses two critical areas for development: prevention and early

intervention and local service expansion in non-mental health settings. Of the proposed appropriation, $10,000,000 would be invested in primary prevention and early intervention and $20,000,000 in local service expansion. Within the local service program, $5,000,000 will be set-aside for projects targeting a reduction in racial/ethnic disparities in mental health, a significant problem highlighted by the Surgeon General's Report on Mental Health and the Department of Health and Human Services (DHHS) Healthy People 2010 mental health goals. All applications must receive State concurrence prior to submission. Each priority initiative will be addressed separately.

In developing future policies applicable to this program, the possibility of including a matching requirement will be considered.

Prevention and Early Intervention Initiative

The 1994 Institute of Medicine (IOM) report *Preventing Mental Illness* concludes:

> "There could be no wiser investment in our country than a commitment to foster the prevention of mental disorders and the promotion of mental health through rigorous research with the highest of methodological standards. Such a commitment would yield the potential for healthier lives for countless individuals and the general advancement of the nations's well-being (Mrazek & Haggerty, 1994, p. xvii)."

In authorizing SAMHSA, Congress specifically instructed the agency "to improve prevention services, [and] promote mental health...." (P.L.102-321, July 10, 1992, p. 106 STAT. 325). Prevention and early intervention is a necessary complement to SAMHSA's commitment to improve access to treatment. Fortunately, as the 1994 IOM study and the 1999 Surgeon General's Report on Mental Health summarize, great strides have been made in developing robust, scientifically-grounded prevention and early intervention programs. CMHS, through this new Prevention TCE will help communities implement and adapt these proven prevention interventions. .

In FY 2001, the Prevention and Early Intervention TCE Initiative will focus on prevention of mental illness and promotion of mental health in children and adolescents. Two CMHS reports, *Reducing risks for mental disorders during the first five years of life,* and *Preventing mental disorders in school-age children* identify specific evidence-based prevention and early intervention programs that applicants for the TCE program can adopt. Approximately 45 awards will be made to cities, counties, and tribal governments to implement programs targeting at-risk children and adolescents, with an emphasis on youth from ethnic/racial minorities. In subsequent years, the TCE program will cover prevention issues across other age groups.

Targeted Capacity Expansion in Non-Mental Health Service Systems Initiative

CMHS proposes a new FY 2001 Targeted Capacity Expansion (TCE) program primarily to strengthen the ability of non-mental health service systems (e.g., primary health care settings, agencies serving the elderly) to better identify and treat mental illness among the people that they serve. A major

epidemiological study of mental illness and substance abuse in the United States, the National Co-morbidity Study (Kessler et al, 1998) found that about half of people with mental illnesses received any treatment for their illness, and well over half of those received treatment from their primary health care provider, from a minister or priest, or from someone other than a trained mental health professional. Often, these other systems are ill equipped and ill informed to effectively recognize and treat mental disorders. But, these systems are where the people are and actually go. CMHS , through this new TCE program, will partner with non-mental health specialty systems to help them better meet the mental health needs of the people whom they already serve.

The data tell us a compelling story. Most psychotropic medications are not prescribed by psychiatrists, but by primary care and other physicians (Pincus et al., 1998). Between 40 and 60% of people with depressive disorder in the U.S. receive their only health care from general medical providers (Wells et al., 1999). Adults and children with mental and emotional problems often rely on their family physicians because they are less stigmatizing and more accessible than mental health specialists. Unfortunately, signs of mental illness are not recognized, or if identified, are not effectively treated by non-mental health settings. For example, the Surgeon General's Report on Mental Health indicates that in primary care settings, major depression goes unrecognized for one-third to one-half of affected patients. Of those treated, it is far from uncommon that wrong medications are prescribed, dosages are inadequate, durations are too short, and drug-interactions are not monitored. Among children and adolescents, the problem of missed opportunities by non-mental health agencies to detect and treat mental illnesses is even more striking than for adults. The Surgeon General's report finds that between 75% and 80% of children with serious emotional disturbances do not receive any specialized mental health care for their problems, and most go completely untreated. The vast majority of children with SED who do receive mental health services (more than 70%) receive help in school (Burns et al, 1995). Many others get what help that they do receive through child welfare, general health and juvenile justice settings.

Access to appropriate care is a particularly pronounced problem for Americans who are racial or ethnic minorities. The Surgeon General reports that the U.S. mental health system is not well-equipped to meet the needs of racial and ethnic minority populations, and that these groups are generally considered to be underserved (1999).

Fortunately, well-designed models designed to improve the capacity of non-specialty systems to provide effective mental health care are producing striking results. Studies in Portland, Los Angeles, Pittsburgh, Connecticut, Texas, elsewhere are showing that non-mental health systems can be assisted to achieve treatment outcomes as good as the best specialty mental health care (Katon, et. al, 1998). Through its KDA programs, CMHS is working with primary health care systems to test models for improving detection and treatment of mental illness in older Americans in primary health care settings. Similar KDA efforts are under way focused on young children, adolescents, homeless adults and families, and adults in the criminal justice system. CMHS' new TCE program is designed to help local communities adapt these proven models to meet emerging and urgent mental health needs primarily through non-specialty service systems.

The Initiative

The TCE program will support development of mental health treatment capacity where the need presents itself: in primary health care and community health centers, health care for homeless and shelter programs, programs for the elderly, and other non-mental health service systems. Each TCE program will two components: Service Linking and Capacity Development.

The Service Linking component will provide resources to grantee communities to build service networks which assure that persons presenting with mental health problems identified in the target service systems will be assessed and treated in that system, or are linked directly into specialty mental health services such as community mental health centers. The Capacity Development component will provide resources to develop specific, evidence-based treatment capacity primarily within non-mental health specialty service systems. CMHS will assist TCE grantees in the selection and implementation of evidence-based interventions. The TCE mechanism will allow local communities to focus on populations and service systems that are most pressing to them through strategic response to the demand for mental health services. It will also build on the strengths and resources of existing service systems, helping them to do a better job with the people that they are already set up to serve. For example, church programs serving the homeless offer caring and trusting relationships, criminal justice programs offer more careful supervision and safety for those who need it, and primary care physicians offer high credibility and long-term health care relationships. The program will provide local communities the opportunity to create on expand their ability to provide integrated, creative responses to well documented treatment capacity expansion. CMHS will consult with other federal agencies, such as the Administration on Aging, on how best to address the mental health issues affecting older Americans.

Grants will be awarded to communities focusing on creating better access for racial/ethnic minorities to linguistically and culturally appropriate mental health care. This improvement may, for example, be achieved through partnerships between primary care and ethnic-specific agencies, or by providing incentives for non-mental health service providers to recognize and discuss mental health/illness in a culturally competent manner. Grantees may also propose other evidence-based approaches to local services expansion which have been created or tailored for use with the target population.

Technical assistance will be provided to applicants through existing CMHS Technical Assistance Centers. Grants will be for 3 years.

Objectives:

- To increase the likelihood of early intervention in mental health problems by providing assessment and mental health treatment in settings where people are already engaged.
- To increase service utilization by improving short- and long-term access to services.
- To promote service system integration by creating and maintaining service networks.
- To implement the "no wrong door" approach to health and support services.
- To improve racial/ethnic minority access to linguistically and culturally appropriate mental health services.

B. CENTER FOR MENTAL HEALTH SERVICES
3. Children's Mental Health Services Program

	1999 Actual	2000 Pre-rescission Appropriation	2000 Final Appropriation	2001 Request	Increase or Decrease
BA	$77,909,000	$83,000,000	$82,763,000	$86,763,000	+$ 4,000,000

2001 Authorization

PHSA Section 565 (f) . . . . . Expired

Purpose and Method of Operation

The Comprehensive Community Mental Health Services for Children and Their Families Program is a discretionary grant and contract program to encourage the development of intensive community-based services for children with serious emotional disturbance and their families based on a multi-agency, multi-disciplinary approach involving both the public and private sectors.

Funds are available to States, political subdivisions of States, territories, and Indian tribes or tribal organizations. Funds are used to build on the existing service infrastructure so that the array of services required to meet the needs of the target population is available and accessible. Grants are limited to a total of 5 years and grantees must develop sources of non-federal matching contributions which must increase over the term of the award from $1 for each $3 of Federal funds in the first year to $2 for each $1 of Federal funds in the final year.

As of 1998, the 45 grantees had generated a total of $183 million of matching non-federal funds in support of their communities' system of care. From 1993- 1999, CMHS has funded 65 grants in 42 states and served a total of 40,827 children.

1999	2000	2001

	Estimate	Estimate	Estimate	Difference
Number of Children Served.....	15,600	15,600	17,300	+ 1,700

The Children's Mental Health Services Program is solidly grounded on a set of well-tested accomplishments. New grantees will be assisted to achieve the kinds of results that CMHS' current grantees are reporting.

Child Outcomes: Findings indicate notable improvements for children after one year in starting services. For example,

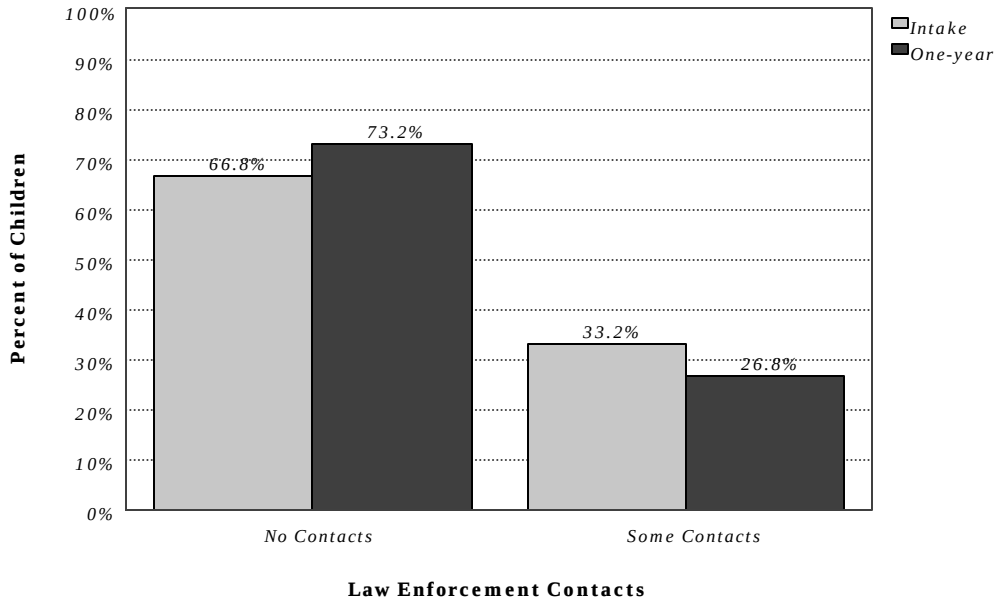
- ***Law Enforcement Contacts Reduced*** - The proportion of children who had no contact with law enforcement increased by 10 percent from 66.8% of children at intake to 73.2% one year later.

- ***Stable Living Arrangements Increased*** - The percent of children who had multiple living arrangements decreased by 32 percent one year after starting services. Similarly, the percent of children having a single living arrangement increased by 19 percent after one year.

- ***School Performance Improved*** - The proportion of children with below average or failing grades decreased by 25 percent after one year. In addition, the percent of children with average or above average school grades increased by 19 percent after one year.

- ***School Attendance Improved*** - The percent of children attending school infrequently (1-75 percent of the time) decreased by 16 percent after one year. Regular attendance increased by 5 percent after one year.

Reduction in Law Enforcement Contacts



Law Enforcement Contacts:
Number of Children = 2743.

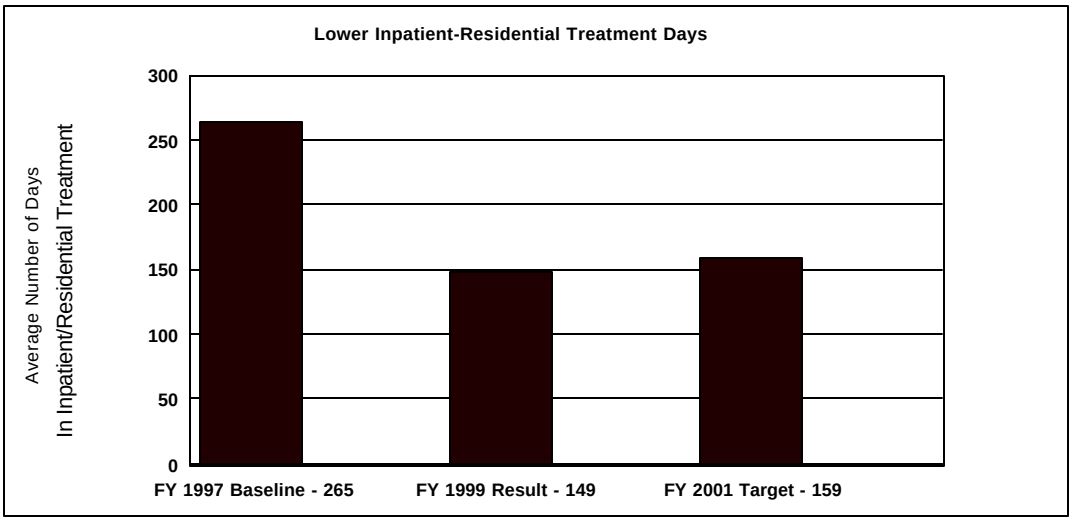
Service System Outcomes - The children's mental health service systems have been able to cut substantially the number of out-of-home residential placements for children in their service area, and reduce the average length out-of-home placements.

Funding levels for the past five fiscal years were as follows:

	Funding	FTEs
1996.....	$ 59,927,000	—
1997.....	69,896,000	—
1998.....	72,927,000	—
1999.....	77,909,000	—
2000.....	82,763,000	—

Rationale for the Budget Request

The FY 2001 President's Budget proposes $86,763,000, an increase of $4,000,000. Of the total amount, $5,000,000 will be used to make 5 new grant awards and $81,673,000 will be for grant continuations and related contract activity. Continued support will be provided for evaluation, technical assistance, and communication activities, promising more improvement in more places for more children and their families in the future.



B. CENTER FOR MENTAL HEALTH SERVICES
4. Protection and Advocacy Program

	1999 Actual	2000 Pre-rescission Appropriation	2000 Final Appropriation	2001 Request	Increase or Decrease
BA	$22,949,000	$25,000,000	$24,903,000	$25,903,000	+$1,000,000

2001 Authorization
P.L. 102-173, Section 117.....Expired

Purpose and Method of Operation

The Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act (42 U.S.C. Chapter 114) authorizes formula grant awards to protection and advocacy (P&A) systems designated by the governor in each of the States, the territories, and the District of Columbia. The PAIMI awards are used by the State P&A systems to ensure protection and advocacy for individuals with mental illness and severe emotional disturbance against abuse, neglect and civil rights violations while in a public or private residential care or treatment facility. The State P&A systems are authorized to monitor compliance with respect to the rights of individuals through activities that ensure the enforcement of the Constitution and federal and State statutes and to investigate incidents of abuse and neglect of individuals if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred.

The goal of this program is to expand the resources and capacity of State P&A systems to provide the following protection and advocacy services to individuals with mental illness and severe emotional disturbance: . . . . . .

- to reduce their waiting lists by funding additional program priorities to meet consumer service needs.
- to meet the needs of unmet populations, such as, children, adolescents, women, the elderly, including ethnic and cultural minorities, in rural and urban care/treatment facilities.
- to monitor the incidents of seclusion and restraint used by public and private residential care and treatment facilities for individuals with mental illness and severe emotional disturbance.
- to investigate all fatal incidents resulting from the use of seclusion and restraint in public and private residential facilities for individuals with mental illness and severe emotional disturbance.

	1999 Estimate	2000 Estimate	2001 Estimate	Difference
Number of Clients Served	16,600	18,000	18,700	+ 700
Number of Complaints Addressed	26,500	29,500	31,000	+1,500

Of the 25,527 abuse, neglect, and rights violation complaints addressed by the State P&A programs in FY 1998, the number of incidents involving abuse increased to 8,687 (FY 97: 8,360). The majority of these incidents involved failure to provide mental health treatment (25%), physical assault (12%), inappropriate or excessive restraint/seclusion (12%), failure to provide medical treatment (10%), and inappropriate or excessive medication (11%). There were also numerous fatalities involving individuals with mental illness who received care or treatment in a residential facility at the time. State P&A systems conducted investigations of these highly publicized deaths and issued findings which substantiated where residential facility staff either used excessive physical restraint or provided inadequate medical care.

For example, one State P&A system decreased incidents of abuse and neglect in a State residential treatment facility through increased monitoring. The facility treated 35 boys and girls, aged 8-17 years, from two contiguous States who were placed their by their respective States because of "trouble with the law." PAIMI staff, while conducting an outreach visit at the facility, asked a little girl about the numerous scratches on her arms and legs. She said "they took me down." The child explained that facility staff "slammed" her against the floor, against the wall or against whatever object was nearby. Other children also explained to PAIMI staff how the facility was managed. PAIMI staff, conducted training for facility staff on the rights of residents. However, the training was not well received by facility staff who became upset, told PAIMI staff that "you can't take away our power," and then disrupted the training session. The children, when provided with patients' right training, thought the PAIMI staff was joking as they thought they had no rights and that it was acceptable for facility staff to physically punish them. PAIMI staff made numerous repeat visits to interview the children who continued to relay incidents of abusive treatment by facility staff.

The PAIMI staff reported these findings to the State (which licensed the facility) Office of Children's Services (OCS), the children's legal custodians. However, OCS made no effort to remedy the situation, PAIMI staff requested that the State's Department of Social services (DSS) investigate the facility. The DSS investigation resulted in OCS removed the children, placed them in a more appropriate placement, and revoked the facilities license to operate. This facility no longer exists.

In FY 1999, incidents involving individuals with mental illness and severe emotional disturbance placed in seclusion and restraint while in residential care and treatment facilities have received increased attention. Exposes by the *Hartford Courant* and *60 Minutes* focused national attention to these incidents and the numerous fatalities resulting from poor quality care. In November 1999, DHHS OIG issued a report [A-01-99-02500, the GAO issued similar findings in September 1999] after assessing the adequacy of State reporting systems to provide information on fatalities, injuries, use of seclusion and restraint, reports of

abuse and neglect, and investigations of these incidents. Selected State P&A systems provided the OIG with information on incidents of seclusion and restraint, especially those involving fatalities.

Funding levels for the past five fiscal years were as follows:

	Funding	FTEs
1996.....	$19,850,000	—
1997.....	21,957,000	—
1998.....	21,957,000	—
1999.....	22,949,000	—
2000.....	24,903,000	—

Rationale for Budget Request

The FY 2001 budget proposes $25,903,000, an increase of $1,000,000. This additional funding will serve at least 700 more individuals. This budget request will provide the 56 State P&A systems with the financial resources needed to expand their capacity to investigate incidents of abuse, such as seclusion, restraint and any fatalities resulting from such incidents, that occur in public and private residential care and treatment facilities for individuals with mental illness, and to monitor these facilities, to protect and advocate on their behalf against abuse, neglect and civil rights violations, and to ensure enforcement of the Constitution, Federal and State laws and regulations on behalf of individuals with mental illness and severe emotional disturbance, especially their capacity to investigate.

Center for Mental Health Services

Protection & Advocacy Program

State or Territory	FY 1999 Actual	FY 2000 Pre-rescission Appropriation	FY 2000 Final Appropriation	FY 2001 Estimate	Difference +/- 2001 vs 2000 Final
Alabama	$307,385	$335,174	$333,873	$347,280	$13,407
Alaska	271,613	295,888	294,740	306,576	11,836
Arizona	314,590	347,245	345,897	359,787	13,890
Arkansas	271,613	295,888	294,740	306,576	11,836
California	2,041,368	2,223,339	2,214,712	2,303,644	88,932
Colorado	271,613	295,888	294,740	306,576	11,836
Connecticut	271,613	295,888	294,740	306,576	11,836
Delaware	271,613	295,888	294,740	306,576	11,836
District of Columbia	271,613	295,888	294,740	306,576	11,836
Florida	951,267	1,044,429	1,040,376	1,082,153	41,777
Georgia	495,779	544,902	542,787	564,583	21,796
Hawaii	271,613	295,888	294,740	306,576	11,836
Idaho	271,613	295,888	294,740	306,576	11,836
Illinois	731,471	800,766	797,659	829,689	32,030
Indiana	393,073	427,141	425,484	442,569	17,085
Iowa	271,613	295,888	294,740	306,576	11,836
Kansas	271,613	295,888	294,740	306,576	11,836
Kentucky	280,610	304,235	303,054	315,223	12,169
Louisiana	311,827	338,132	336,820	350,345	13,525
Maine	271,613	295,888	294,740	306,576	11,836
Maryland	309,207	335,870	334,567	348,002	13,435
Massachusetts	358,432	386,931	385,430	400,906	15,476
Michigan	629,518	685,690	683,029	710,456	27,427
Minnesota	296,176	321,373	320,126	332,980	12,854
Mississippi	271,613	295,888	294,740	306,576	11,836
Missouri	359,193	391,204	389,686	405,334	15,648
Montana	271,613	295,888	294,740	306,576	11,836
Nebraska	271,613	295,888	294,740	306,576	11,836
Nevada	271,613	295,888	294,740	306,576	11,836
New Hampshire	271,613	295,888	294,740	306,576	11,836
New Jersey	463,140	502,844	500,893	521,006	20,113
New Mexico	271,613	295,888	294,740	306,576	11,836
New York	1,072,815	1,159,373	1,154,875	1,201,249	46,374
North Carolina	500,214	547,988	545,862	567,781	21,919
North Dakota	271,613	295,888	294,740	306,576	11,836

Center for Mental Health Services
Protection & Advocacy Program

State or Territory	FY 1999 Actual	FY 2000 Pre-rescission Appropriation	FY 2000 Final Appropriation	FY 2001 Estimate	Difference +/- 2001 vs 2000 Final
Ohio	735,314	796,090	793,001	824,844	31,843
Oklahoma	271,613	295,888	294,740	306,576	11,836
Oregon	271,613	295,888	294,740	306,576	11,836
Pennsylvania	768,827	826,662	823,455	856,521	33,066
Rhode Island	271,613	295,888	294,740	306,576	11,836
South Carolina	271,613	296,636	295,485	307,350	11,865
South Dakota	271,613	295,888	294,740	306,576	11,836
Tennessee	363,170	398,040	396,496	412,417	15,921
Texas	1,299,717	1,417,013	1,411,514	1,468,194	56,680
Utah	271,613	295,888	294,740	306,576	11,836
Vermont	271,613	295,888	294,740	306,576	11,836
Virginia	426,026	463,574	461,775	480,317	18,542
Washington	355,198	386,170	384,672	400,118	15,446
West Virginia	271,613	295,888	294,740	306,576	11,836
Wisconsin	340,093	371,631	370,189	385,054	14,865
Wyoming	271,613	295,888	294,740	306,576	11,836
Puerto Rico	477,560	520,081	518,063	538,866	20,803
American Somoa	145,584	158,595	157,980	164,324	6,344
Guam	145,584	158,595	157,980	164,324	6,344
North Mariana Islands	145,584	158,595	157,980	164,324	6,344
Virgin Islands	145,584	158,595	157,980	164,324	6,344
Total, States & Territories	22,497,857	24,500,001	24,404,940	25,384,940	980,000
Set-Aside	451,143	499,999	498,060	518,060	20,000
TOTAL P&A	$22,949,000	$25,000,000	$24,903,000	$25,903,000	$1,000,000

B. CENTER FOR MENTAL HEALTH SERVICES
5. Projects for Assistance in Transition from Homelessness (PATH)

	1999 Actual	2000 Pre-rescission Appropriation	2000 Final Appropriation	2001 Request	Increase or Decrease
BA	$25,991,000	$31,000,000	$30,883,000	$35,883,000	+$ 5,000,000

2001 Authorization

PHSA Section 535 (a) ..... Expired

Purpose and Method of Operation

The Projects for Assistance in Transition from Homelessness (PATH) program was established in FY 1991 to provide community support services to individuals with serious mental illness who are homeless or at risk of becoming homeless. Eligible services funded include: outreach; screening and diagnostic treatment; habilitation and rehabilitation; community mental health services; alcohol or drug treatment (for individuals with serious mental illness and co-occurring substance use disorders); staff training; case management; supportive and supervisory services in residential settings; and referrals for primary health care, job training, and education. In addition, to coordinating services and housing for the target population, a limited set of housing services may be funded.

PATH delegates to States responsibility to determine their own priorities from among the wide array of eligible services. Under PATH, States are encouraged to develop and implement outcome measures and have considerable flexibility to determine goals, objectives and outcomes. The PATH program requires matching funds of $1 to every $3 of federal funds. In 1998, State and local matching funds were about twice as much as the required amount.

The PATH program contributes to, and benefits from, the CMHS' Knowledge Development and Application strategy. PATH funded programs serve both as sources and recipients of knowledge concerning exemplary practices in the delivery of mental health services for the homeless.

	1999 Estimate	2000 Estimate	2001 Estimate	Difference
Number of Persons Contacted	102,000	109,000	118,000	+9,000

Clients Served: The most recent program data indicate that in FY 1998, 365 local agencies and/or counties received PATH funding. Adults in the age range 18-64 comprised 93 percent of the clients enrolled in services. Thirty three percent were African-American; 6 percent were of Hispanic origin. Clients

receiving PATH-funded services have some of the most disabling mental disorders. For the States reporting diagnostic information, the most common diagnoses were schizophrenia and other psychotic disorders (43 percent), followed by affective disorders (35 percent). Fifty nine percent of clients served had a co-occurring substance use disorder in addition to a serious mental illness.

Rationale for the Budget Request

The proposed funding for this program in FY 2001 is $35,883,000, an increase of $ 5,000,000 over the FY 2000 final appropriation. As a result of this increase, PATH providers will fulfill the following PATH GPRA goals: (1) contact a total of 118,000 persons, targeting outreach and other services to those most in need; (2) maintain at the level of at least 33%, the percentage of persons contacted who become enrolled clients, even though these persons will be more difficult to engage, and; (3) maintain at the level of at least 80 percent, the percentage of participating agencies that offer outreach services.

PATH funded programs will improve strategies in outreach and service delivery through the adoption of exemplary practices and PATH-specific outcome measures. CMHS will continue to work with States to implement evidence-based practices in local communities to reduce the level of homelessness among persons with mental illness.

Center for Mental Health Services
PATH Program

State or Territory	FY 1999 Actual	FY 2000 Pre-rescission Appropriation	FY 2000 Final Appropriation	FY 2001 Estimate	Difference +/- 2001 vs 2000 Current
Alabama	$300,000	$300,000	$300,000	$344,000	$44,000
Alaska	300,000	300,000	300,000	300,000	---
Arizona	314,000	409,000	407,000	497,000	90,000
Arkansas	300,000	300,000	300,000	300,000	---
California	3,015,000	3,920,000	3,900,000	4,765,000	865,000
Colorado	300,000	366,000	364,000	445,000	81,000
Connecticut	300,000	378,000	376,000	460,000	84,000
Delaware	300,000	300,000	300,000	300,000	---
District of Columbia	300,000	300,000	300,000	300,000	---
Florida	1,205,000	1,567,000	1,559,000	1,904,000	345,000
Georgia	386,000	502,000	499,000	610,000	111,000
Hawaii	300,000	300,000	300,000	300,000	---
Idaho	300,000	300,000	300,000	300,000	---
Illinois	1,004,000	1,305,000	1,298,000	1,587,000	289,000
Indiana	319,000	415,000	412,000	504,000	92,000
Iowa	300,000	300,000	300,000	300,000	---
Kansas	300,000	300,000	300,000	300,000	---
Kentucky	300,000	300,000	300,000	300,000	---
Louisiana	300,000	343,000	341,000	417,000	76,000
Maine	300,000	300,000	300,000	300,000	---
Maryland	424,000	551,000	548,000	670,000	122,000
Massachusetts	560,000	728,000	724,000	885,000	161,000
Michigan	688,000	895,000	890,000	1,088,000	198,000
Minnesota	300,000	365,000	363,000	444,000	81,000
Mississippi	300,000	300,000	300,000	300,000	---
Missouri	329,000	428,000	426,000	521,000	95,000
Montana	300,000	300,000	300,000	300,000	---
Nebraska	300,000	300,000	300,000	300,000	---
Nevada	300,000	300,000	300,000	300,000	---
New Hampshire	300,000	300,000	300,000	300,000	---
New Jersey	785,000	1,021,000	1,015,000	1,241,000	226,000
New Mexico	300,000	300,000	300,000	300,000	---
New York	1,671,000	2,173,000	2,162,000	2,641,000	479,000
North Carolina	300,000	387,000	385,000	470,000	85,000
North Dakota	300,000	300,000	300,000	300,000	---

Center for Mental Health Services
PATH Program

State or Territory	FY 1999 Actual	FY 2000 Pre-rescission Appropriation	FY 2000 Final Appropriation	FY 2001 Estimate	Difference +/- 2001 vs 2000 Current
Ohio	788,000	1,025,000	1,019,000	1,246,000	227,000
Oklahoma	300,000	300,000	300,000	300,000	---
Oregon	300,000	300,000	300,000	300,000	---
Pennsylvania	853,000	1,110,000	1,104,000	1,349,000	245,000
Rhode Island	300,000	300,000	300,000	300,000	---
South Carolina	300,000	300,000	300,000	300,000	---
South Dakota	300,000	300,000	300,000	300,000	---
Tennessee	300,000	341,000	340,000	415,000	75,000
Texas	1,346,000	1,751,000	1,742,000	2,128,000	386,000
Utah	300,000	300,000	300,000	300,000	---
Vermont	300,000	300,000	300,000	300,000	---
Virginia	453,000	590,000	586,000	717,000	131,000
Washington	381,000	495,000	492,000	602,000	110,000
West Virginia	300,000	300,000	300,000	300,000	---
Wisconsin	300,000	379,000	377,000	461,000	84,000
Wyoming	300,000	300,000	300,000	300,000	---
Puerto Rico	300,000	327,000	325,000	398,000	73,000
American Somoa	50,000	50,000	50,000	50,000	---
Guam	50,000	50,000	50,000	50,000	---
North Mariana Islands	50,000	50,000	50,000	50,000	---
Virgin Islands	50,000	50,000	50,000	50,000	---
Total, States & Territories	25,221,000	30,071,000	29,954,000	34,809,000	4,855,000
Set-Aside	770,000	929,000	929,000	1,074,000	145,000
TOTAL, PATH	$25,991,000	$31,000,000	$30,883,000	$35,883,000	$5,000,000

B. CENTER FOR MENTAL HEALTH SERVICES
6. Block Grant for Community Mental Health Services

	1999 Actual	2000 Pre-rescission Appropriation	2000 Final Appropriation	2001 Request	Increase or Decrease
BA	$288,816,000	$356,000,000	$356,000,000	$416,000,000	+$ 60,000,000
FTEs	11	17	17	17	----

2001 Authorization

Mental Health Block Grant . . . . . Expired

Purpose and Method of Operation

The Block Grant for Community Mental Health Services supports the development of comprehensive community-based systems of care for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). Formula grants are awarded to States and Territories in response to an application and implementation report on prior fiscal year activities. Applications are developed with the involvement of State mental health planning councils and must include goals, objectives and performance indicators. The Mental Health Block Grant (MHBG) has consistently served as a catalyst and provided the impetus for States to develop community-based systems of care and dramatically reduce the use of State psychiatric hospital care. The goal of the (MHBG) program is to move the locus of care for adults with SMI and children with SED from costly and restrictive inpatient hospital care to communities where they can receive the necessary treatment and supports to live self-fulfilling, productive lives.

The MHBG targets the following populations for community-based services:

- Adults with serious mental illness who:
  - have a history of repeated psychiatric hospitalizations or repeated use of intensive community services; or
  - have co-occurring substance abuse disorders and mental illness; or
  - have a history of interactions with the criminal justice system; or
  - are currently homeless.

- Children with serious emotional disturbance who:
  - are at risk of out-of-home placement; or
  - have co-occurring substance abuse disorders and emotional disturbance; or

- as a result of their disorder are at high risk for the following significant adverse outcomes: attempted suicide; parental relinquishment of custody; a brush with the law; behavior dangerous to self or others; running away or being homeless.

	1999 Estimate	2000 Estimate	2001 Estimate	Difference
Number of Persons Served	160,000	195,000	230,000	+35,000

State and local governments traditionally have been the major payers for public mental health services and this remains the case today. The Mental Health Block Grant serves as a flexible and significant funding source that the States use to promote community-based services.

Funding levels for the past five fiscal years were as follows:

	Funding	FTEs
1996.....	$275,420,000	11
1997.....	275,420,000	11
1998.....	275,420,000	11
1999.....	288,816,000	11
2000.....	356,000,000	17

For the first time, there are now prevalence rates by State for adults with SMI and children with SED. The CMHS provided the States in its FY 1999 application a menu of illustrative performance indicators and core outcome measures for States to use in the development of their State mental health plans. This menu was a precursor to the 28 indicators studied in the Five State Feasibility Study which were later refined by the National Association of State Mental Health Program Directors President's Task For on Performance Indicators.

In the FY 1999 Implementation Report, 27 States, or 54% did not report on the core measures or were unable to provide data on them. A total of 23 (46%) of the States provided data provided data on one or more of the core measures. Three of the States, or 6%, reported on all six of the core measures, however only 16% of the States were able to report on four or more of them. The largest number of States (9) reported data on two of the six core measures.

Data Elements Used to Calculate State Allotments

FY 2000: The Congressional appropriation language specified that "...the amount of the allotment of a State under section 1911 shall not be less than the amount the State received under Section 1911 for fiscal year 1998." The factors and their data sources used to calculate the allotments in the FY 2000 table are:

- Total Personal Income (TPI) - Bureau of Economic Analysis, Department of Commerce, downloaded from BEA web site *http://www.bea.doc.gov/bea/dr/spitbl-d.htm#table2* - Table 2, Personal Income by State and Region, 1993-1997, release date 9/14/98, also available from *http://www.bea.doc.gov/bea/ar1098rem/table1.htm.*

- Resident Population - Bureau of the Census, Department of Commerce, downloaded from Census web site, text file AG9797.txt, 1990-to-1997 Annual Time Series of Population Estimates by Age and Sex, By Single Year of Age and Sex, public release date 7/21/98. Census website is *http://www.census.gov/population/estimates/state/stats/ag9797.txt.* (data as of 7/1/97).

- Total Taxable Resources (TTR) - Office of Economic Policy, Department of the Treasury, provided directly to OAS via e-mail, filename NM98EST.wk4, release date 9/30/98, Total Taxable Resources, 1994-1996.

- Population data for the territories based on 1990 Census Data except Micronesia and the Marshall Islands. Population data for Micronesia and the Marshall Islands are based on 1980 census data and the average rate of population change from the 1980 to the 1990 census. Because Micronesia and the Marshall Islands had entered into a Compact of Free Association with the United States, they were no longer considered territories in 1990 and therefore were not included in the 1990 census.

- A Cost of Services Factor which includes the following: Fair Market Rents for the Section 8 Housing Assistance Payments Program — Fiscal year 1997, from the U.S. Department of Housing and Urban Development, *Federal Register*, September 20, 1996, Vol. 61, No. 184, pages 49576-49635, from website *http://www.hud.gov* and then *ftp@ftp.aspemsys.com*. 1990 Census mean hourly wages for selected industries and occupations (special data file prepared by the Bureau of the Census) updated using the percent change for HCFA mean hourly hospital wages (unadjusted) for FY 1990 (from a special data file prepared by the Health Care Financing Administration) and FY 1993 hourly hospital wages developed from the FY 1997 HCFA Hospital Inpatient Prospective Payment System Wage Rates [published in the *Federal Register*, August 30, 1996, Vol. 61, Number 170, pages 46165-46215 with corrected data published in the *Federal Register* December 19, 1996, Vol. 61, Number 245, pages 66919-66923] in the HCFA public use file "HCFA Hospital Wage Index Survey File" of Hospital Inpatient Prospective Payment System FY 1997 Rates downloaded from website *http://www.hcfa.gov/stats/pufiles.htm* and corrected per the December 1996 revisions.

FY 2001: The factors and their data sources used to calculate the allotments in the FY 2001 table are:

- Total Personal Income (TPI) - Bureau of Economic Analysis, Department of Commerce, downloaded from BEA web site http://www.bea.doc.gov/bea/regional/spi/summary.htm State Personal Income, 1994-1998, release date 7/27/1999.

- Resident Population - Bureau of the Census, Department of Commerce, downloaded from Census website, text file AG9898.txt, Population Estimates for the U.S. and States by Single Year of Age and Sex: July 1, 1998, public release date 6/15/1999. Census web site is http://www.census.gov/population/estimates/state/stats/.

- Total Taxable Resources (TTR) - Office of Economic Policy, Department of the Treasury, provided directly to OAS via e-mail, filename NM99EST.wk4, release date 9/30/1999, Total Taxable Resources, 1995-1997, now also available on the Treasury web site http://www.treas.gov/ttr.

- Population data for the territories based on 1990 Census Data except Micronesia and the Marshall Islands. Population data for Micronesia and the Marshall Islands are based on 1980 census data and the average rate of population change from the 1980 to the 1990 census. Because Micronesia and the Marshall Islands had entered into a Compact of Free Association with the United States, they were no longer considered territories in 1990 and therefore were not included in the 1990 census.

- A Cost of Services Index Factor, updated for this fiscal year under a three-year periodic update, which includes the following:

  Fair Market Rents for the Section 8 Housing Assistance Payments Program — Fiscal Year 2000, downloaded from the HUD web site http://www.huduser.org/datasets/fmr: (a) fmr2000f.dbf, dbase file, released 10/1/99, created 9/23/99 (dbase is the only machine-readable format in which the raw data are offered); (b) fmr2000f.txt, text file, FMR data record layout and file description, released 10/1/99, created 9/27/99; (c) 2000f_pre.doc, Word file, Federal Register preamble of the FY2000 FMR calculations, released 10/1/99; and (d) fmrover.wp, WordPerfect version of the Federal Register preamble.
  Metropolitan Areas, 1999, released by the Office of Management and Budget 6/30/99, filename MSA99.pdf; used by HUD in development of FMR rates.

  Changes in Metropolitan Areas as Defined by the Office of Management and Budget Since June 30, 1999, filename MAUPDATE.txt, released 6/30/99, Bureau of the Census.

  1990 Census mean hourly wages for selected industries and occupations (special data file prepared by the Bureau of the Census) updated using the percent change for HCFA mean hourly hospital wages (unadjusted) for FY 1990 (from a special data file prepared by the Health Care Financing Administration) and FY 1996 hourly hospital wages

developed from data collected for the establishment of FY 2000 HCFA Hospital Inpatient Prospective Payment System Wage Rates, collected from the HCFA Internet web site http://www.hcfa.gov/stats/pufiles, publically available on August 17, 1999. Both executable and zip versions of the data file WAGEDATA.F96 were available on the web site as 1.2 MB self-extracting files which decompressed to a 5 MB fixed length (i.e. "flat") ASCII file consisting of 5,038 records (one record for each unique facility reporting to HCFA) - the executable version was downloaded and decompressed. Also downloaded was the file for the data record layout (WDF2000), which was available in several formats. Guidance was also provided by HCFA regarding relevant changes which occurred in reporting format between the FY 1997 and FY 2000 hospital wage data releases.

Rationale for the Budget Request

The FY 2001 budget proposes an increase of $60 million, for a total of $416 million. Each State and Territory will receive an increase over its FY 2000 allotment to improve community-based mental health services. This increase will provide services to approximately 35,000 additional clients per year for a total of 230,000 clients. These figures are based on the average claimant costs for ambulatory care of $1,718 per client per year.

The severity of gaps in the community based systems of care for persons with SMI was brought to the forefront in 1999 with the recent Supreme Court decision in Olmstead v. L.C., 119 S. Ct. 2176 (1999). In this ruling the Supreme Court interpreted Title II of the Americans with Disabilities Act and determined that the unnecessary segregation of persons in state psychiatric facilities and other long term care programs constitutes discrimination. The Olmstead case was brought by two Georgia women whose disabilities included mental retardation and mental illness. At the time the suit was filed, both plaintiffs lived in State-run institutions, despite the fact their treatment professionals had determined they could be appropriately served in community settings. The plaintiffs asserted that continued institutionalization was a violation of their rights under the ADA to live in the most integrated setting appropriate.

Under the Court's decision, States are required to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when: (a) the State's treatment professionals reasonably determine that such placement is appropriate; (b) the affected persons do not oppose such treatment; and (c) the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others who are receiving State-supported disability services.

Olmstead is a serious challenge to States to prevent and correct inappropriate institutionalization and to review intake and admissions processes to assure that persons with disabilities are served in the most integrated setting appropriate. Olmstead obliges States to administer their services programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

A $60 million increase to the Mental Health Block Grant Program is expected to be critical in enabling State mental health authorities to significantly influence efforts to reorganize health care delivery systems to ensure sufficient access to quality mental health care for under served populations. The increase will help States' youth violence abatement programs, jail diversion programs for youth, post-incarceration and post-hospitalization community service programs, and community-based suicide prevention programs for youth and the elderly. This increase will permit States and communities to focus on the gaps between needs and services, such as case management or school-based services for persons who do not meet the criteria for other funding streams, yet for whom services would prevent suffering and increased expenditures at later points of entry for care. States will be better equipped to respond to mental health needs of persons moving from welfare to work as a result of welfare reform legislation and to co-occurring disorders among individuals with mental health and substance abuse problems.

By statute, 5% of the MHBG may be set-aside to gather data, provide technical assistance, and evaluate the program. These funds ensure accountability and promote data-based quality improvement. CMHS has worked with States to build their mental health data infrastructures so that they can report uniform process and outcome information about services supported by the block grant. Significant progress has been made through a 16-State pilot study. Much work is still needed. For example, only 27 States have public mental health data systems that can provide unduplicated counts of clients served. In FY 2001, CMHS will work with all of the States to improve their performance and outcome monitoring systems.

The MHBG set-aside also is used to furnish States with the technical assistance they need to bolster and support their community mental health systems. CMHS continues to meet States information and technical assistance needs in such areas as:

- developing management information systems;
- implementing systems of managed care;
- targeting individuals with co-occurring substance abuse disorders and mental illness for services;
- strengthening State mental health planning and advisory councils;
- transition planning for adults and adolescents;
- providing outreach to youth in the juvenile justice system;
- expansion of services to the elderly;
- collecting data; and
- providing services in a culturally competent manner.

Center for Mental Health Services
Mental Health Block Grant Program

State or Territory	FY 1999 Actual	FY 2000 Pre-rescission Appropriation	FY 2000 Final Appropriation	FY 2001 Estimate	Difference +/- 2001 vs 2000 Current
Alabama	$3,971,612	$5,247,803	$5,247,803	$6,161,478	$913,675
Alaska	588,437	715,829	715,829	755,639	39,810
Arizona	4,579,039	5,734,460	5,734,460	6,593,961	859,501
Arkansas	2,316,177	2,985,186	2,985,186	3,573,035	587,849
California	35,155,183	46,170,018	46,170,018	54,132,223	7,962,205
Colorado	3,750,325	4,313,213	4,313,213	5,045,653	732,440
Connecticut	3,241,039	3,994,050	3,994,050	4,530,053	536,003
Delaware	730,894	801,763	801,763	934,591	132,828
District of Columbia	596,523	720,407	720,407	822,386	101,979
Florida	15,386,850	20,004,734	20,004,734	23,963,730	3,958,996
Georgia	7,389,430	9,664,928	9,664,928	11,802,506	2,137,578
Hawaii	1,243,596	1,494,983	1,494,983	1,666,465	171,482
Idaho	1,070,863	1,378,861	1,378,861	1,666,513	287,652
Illinois	11,194,433	13,451,179	13,451,179	16,094,219	2,643,040
Indiana	6,332,808	7,019,264	7,019,264	8,142,032	1,122,768
Iowa	2,740,750	3,071,528	3,071,528	3,553,657	482,129
Kansas	2,374,949	2,767,226	2,767,226	3,242,305	475,079
Kentucky	3,733,632	4,836,151	4,836,151	5,624,157	788,006
Louisiana	4,376,363	5,289,531	5,289,531	6,044,284	754,753
Maine	1,265,584	1,500,026	1,500,026	1,745,490	245,464
Maryland	5,707,845	6,951,146	6,951,146	8,304,602	1,353,456
Massachusetts	6,360,517	7,488,782	7,488,782	8,362,970	874,188
Michigan	10,771,969	11,633,936	11,633,936	13,151,790	1,517,854
Minnesota	4,438,360	4,895,304	4,895,304	5,773,010	877,706
Mississippi	2,531,443	3,277,046	3,277,046	3,827,346	550,300
Missouri	4,797,839	5,864,082	5,864,082	6,822,133	958,051
Montana	873,926	1,028,398	1,028,398	1,202,030	173,632
Nebraska	1,367,377	1,727,251	1,727,251	1,992,117	264,866
Nevada	1,689,409	2,185,130	2,185,130	2,730,375	545,245
New Hampshire	1,154,144	1,279,932	1,279,932	1,434,964	155,032
New Jersey	8,107,027	10,302,377	10,302,377	11,997,425	1,695,048
New Mexico	1,490,170	1,872,498	1,872,498	2,160,578	288,080
New York	18,640,661	23,765,183	23,765,183	27,988,488	4,223,305
North Carolina	6,498,831	8,483,792	8,483,792	9,855,277	1,371,485
North Dakota	579,458	735,029	735,029	845,712	110,683

Center for Mental Health Services
Mental Health Block Grant Program

State or Territory	FY 1999 Actual	FY 2000 Pre-rescission Appropriation	FY 2000 Final Appropriation	FY 2001 Estimate	Difference +/- 2001 vs 2000 Current
Ohio	12,772,348	12,845,283	12,845,283	14,884,411	2,039,128
Oklahoma	3,049,628	3,896,203	3,896,203	4,552,774	656,571
Oregon	3,228,481	3,741,020	3,741,020	4,231,845	490,825
Pennsylvania	12,024,336	14,411,620	14,411,620	16,276,628	1,865,008
Rhode Island	1,013,252	1,284,233	1,284,233	1,442,314	158,081
South Carolina	3,451,050	4,493,573	4,493,573	5,359,600	866,027
South Dakota	611,875	779,348	779,348	891,414	112,066
Tennessee	4,896,610	6,404,231	6,404,231	7,869,667	1,465,436
Texas	19,588,185	25,320,364	25,320,364	29,068,355	3,747,991
Utah	1,654,986	2,205,056	2,205,056	2,641,978	436,922
Vermont	611,017	688,670	688,670	808,330	119,660
Virginia	6,982,802	8,918,079	8,918,079	10,559,779	1,641,700
Washington	6,001,118	7,139,921	7,139,921	8,446,027	1,306,106
West Virginia	1,941,957	2,246,329	2,246,329	2,605,777	359,448
Wisconsin	5,001,980	5,692,136	5,692,136	6,620,278	928,142
Wyoming	382,485	409,908	409,908	469,625	59,717
Puerto Rico	3,570,111	4,425,283	4,425,283	5,178,541	753,258
American Somoa	50,000	58,768	58,768	68,772	10,004
Guam	134,969	167,300	167,300	195,777	28,477
Marshall Islands	50,000	56,208	56,208	65,775	9,567
Micronesia	107,349	133,062	133,062	155,712	22,650
North Mariana Islands	50,000	54,461	54,461	63,731	9,270
Palau	50,000	50,000	50,000	50,000	0
Virgin Islands	103,199	127,918	127,918	149,692	21,774
Total, States & Territories	274,375,201	338,200,000	338,200,000	395,200,000	57,000,000
Set-Aside	14,440,799	17,800,000	17,800,000	20,800,000	3,000,000
TOTAL, MHBG	$288,816,000	$356,000,000	$356,000,000	$416,000,000	$60,000,000

C. Center for Substance Abuse Prevention
Overview

	1999 Actual	2000 Pre-rescission Appropriation	2000 Final Appropriation	2001 Estimate	Increase or Decrease
BA	**$479,800,000**	**$467,305,000**	**$466,824,000**	**$468,429,000**	**+$1,605,000**

As the primary federal agency responsible for substance abuse prevention, CSAP's goal is to reduce substance abuse across this nation. CSAP's unique niche is serving as the bridge from research to practice though: 1) *Knowledge Development* or field-testing evidence-based approaches to see if they remain effective with diverse populations and implemented under real world conditions, and 2) *Knowledge Application* or developing user-friendly and culturally-appropriate dissemination materials, technical assistance and training programs to increase the capacity of States and communities to adopt these effective prevention programs. CSAP's *High Risk Youth* program dedicates knowledge development resources to field testing research-based programs among specific populations of youth who are at increased risk of substance abuse. Through partnership efforts with other Federal agencies, States, and communities, the *Targeted Capacity Expansion (TCE)* program addresses emerging needs for drug abuse prevention, and improves the accessibility and quality of prevention services. The 20 percent prevention component of the Substance Abuse Block Grant is the primary source of state prevention program support.

Substance abuse is a serious public health problem costing taxpayers $246 billion or about $1,000 per person annually. If you add tobacco, the cost rises to $428 billion. Substance abuse is related to many health problems (e.g., violence and aggression, teenage pregnancies, fetal alcohol and drug syndrome, car crashes, HIV/AIDS, accidental injuries, depression, and suicide). The most cost-effective way to reduce these high personal and economic losses is by preventing them.

Substance abuse prevention is a key component of a comprehensive health strategy. Once a person is a drug abuser, significant damage has already occurred which could have been avoided by providing science-based positive youth development, family strengthening and community mobilization programs. The U.S. Census Bureau projects a 21% increase in the number of youth aged 12-20 or 6.5 million more young people over the next 15 years. Early childhood and adolescence is the most vulnerable age for alcohol and drug initiation and abuse. Hence, investment in primary prevention remains a federal priority. If we do not have an immediate 50% reduction in the initiation rate of alcohol and drug use and the rate of initiation remains the same, the demand for treatment will increase by 57% in the next 15 years. Reducing the initiation rate is essential in any comprehensive effort to close the treatment gap.

Drug abuse in youth is still at unacceptably high levels. Adolescent drug use rose from 5.3 percent monthly use at its lowest point in 1992 to a high of 11.4 percent in 1997. The SAMHSA Household Survey suggests a leveling off or a decrease in 1998 and the Monitoring the Future Study released in December 1999 suggests this downward trend is continuing (MTF shows a 2 year decline among 8th graders). While this is good news it does not mean that we can relax our focus on prevention. We must continue to strive toward the National Drug Control Strategy goal to reduce initiation rates by 2007.

As recently as five years ago, only a very few effective prevention strategies had been identified. Since that time, new prevention strategies have been identified as being effective in preventing, reducing, or delaying the onset of substance abuse. Effective prevention programs include behavioral parent training, family and children's skills training, mentoring and tutoring, school climate change, after school programs, policy changes, community coalitions, and others. They work not only to reduce tobacco, alcohol and drug abuse in youth, but also to improve developmental outcomes and mental health.

We have also learned some prevention approaches do not work. Drug education alone does not work without behavior changes promoted through social and life skills training programs. Behavioral parent training, family skills training, family therapy, and in-home family support programs are highly effective. A recent meta-analysis commissioned by CSAP found that family strengthening programs were 9 times more powerful in reducing the risks for drug abuse than the most powerful school-based programs.

CSAP efforts are critical to the dissemination of effective prevention programs developed by SAMHSA and NIH research grants. Through rigorous evaluation of CSAP programs and collaboration with NIH, we have identified a number of effective prevention programs. CSAP has conducted the cross-site field-trials to see if they still work with diverse populations and reduced experimental control; and CSAP and other federal and state agencies have disseminated these effective prevention programs. We have included a number of effective CSAP prevention programs within a National Registry of Effective Prevention Programs. The 25 State Incentive Grant (SIG) states must use 85 percent of their grant funds to expand the use of evidence-based prevention programs in communities. Further, all grantees in the Community-Initiated and Family Strengthening grant programs must identify, culturally-adapt, implement and evaluate only evidence-based prevention programs.

The value of CSAP's program agenda is supported by the following points:

- **CSAP's Prevention Programs Reduce Substance Abuse**. All of CSAP's cross-site studies have produced positive results and valuable lessons learned. The *Community Partnership Grant Program* implemented in 251 communities reduced the rates of alcohol and drug use in both adolescent and adult males. This year we found through cross-site analyses of 49 grants that overall our *High Risk Youth Program grants* were effective in reducing substance use in adolescent boys (see following accomplishment description). More work is required to identify and disseminate gender-relevant prevention approaches. Those for girls need to be more family-focused rather than the social and recreational skills training approaches found effective for boys. Hence, we are now seeing progress and must continue field-testing and disseminating evidence-

based approaches through CSAP's Knowledge Development (KD) cross-site community studies and CSAP's Knowledge Application (KA) systems.

- **CSAP's Prevention Programs Also Reduce Aggression, Violence, Depression, Suicide, and School Failure.** The High Risk Youth program has shown that precursors of drug use can be prevented. CSAP has proven solutions that need to be disseminated to reduce school and community violence. Every cross-site prevention study that CSAP has completed has demonstrated positive reductions in the precursors of drug use--youth aggression, violence, and mental health problems. CSAP's *High Risk Youth*, *Community Partnership* and *Developmental Predictor Variable* cross-site evaluations all demonstrate that CSAP-funded substance abuse prevention strategies are also effective in reducing conduct disorders and aggression, depression, school failure, and family conflict while improving school bonding, cooperation, and academic performance.

- **CSAP's Programs Identify and Promote Effective Prevention Practices.** CSAP systematically reviews and evaluates community-based substance abuse prevention programs. We have identified seven exemplary prevention programs from our High Risk Youth grant portfolio as well as other NIH and state prevention programs. These evidence-based programs are being disseminated widely in Here's Proof Prevention Works kit through the National Clearinghouse for Alcohol and Drug Information (NCADI), through six regional training centers (CAPTs), and partnerships with national organizations like the National Association of Elementary School Principals, Boys and Girls Clubs and the National Civic Alliance of national service clubs such as the Lions, Rotary, Elks, 100 Black Men, and faith communities.

- **CSAP Programs Improve the Quality of Prevention Services.** By the end of FY 2000, CSAP SIG program will have funded half of all the States for $2 to 3 million dollars each with a mandate to use 85% of grant funds for implementing science-based programs. CSAP's six regional Centers for the Application of Prevention Technologies (CAPTs) work with communities to provide technical assistance and training in selecting and implementing the best prevention programs to meet their local needs. CSAP provides leadership from the six regional CAPTs to the ONDCP/Department of Justice's Drug Free Communities grantees through training in identifying and implementing best prevention practices. Improving the quality of prevention services offered throughout the Nation will improve prevention service effectiveness and outcomes and reduce substance abuse.

- **CSAP Programs Improve the Availability of Prevention Services.** The State Incentive Grant (SIG) program requires states to mobilize all state and community stakeholders to develop a comprehensive state plan, to coordinate and leverage many different prevention funding streams, and to implement and evaluate evidence-based prevention approaches that are coordinated and match local needs assessments. This SIG grant program has reduced services duplication and resulted in more cost-effective and cost-efficient allocation of prevention resources. The outcome

is greater availability of quality programs reaching a greater number of individuals in need of these services.

- **CSAP Programs Build Stronger Federal/State/Local Partnerships.** CSAP is taking the lead in promoting partnerships among public and private agencies to build a more effective National Prevention System. CSAP partners with other Federal agencies to support: 1) *States* in gaining maximum benefit from their prevention expenditures, including the 20% prevention set aside within the Substance Abuse Prevention and Treatment Block Grant; and 2) *local communities* in accessing and applying science-based practices. A National Substance Abuse Prevention Framework was created last March by the 500 delegates attending CSAP's National Prevention Congress. It includes the two major prevention goals from the White House National Drug Control Strategy and 30 new prevention objectives based on what additional knowledge is needed to reduce drug use in this country. This framework is being used by states and CSAP to develop their own coordinated strategic plans. Communities are registering on a dedicated web site their activities under each of the 30 objectives to create a national action plan for prevention and annual report card on accomplishments. A process for voluntary reporting on CSAP's Core Outcome Measures and Minimum Data Set process measures is also being developed.

- **CSAP Programs Support National Demand Reduction Goals**. CSAP programmatic efforts are directly in support of the President's National Drug Control Strategy (NDCS). Predominantly addressing the NDCS Goal 1, *Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco,* CSAP efforts focus on impact targets relating to reducing the prevalence of past month use of illegal drugs and alcohol among youth by 20 percent by 2002 and by 50 percent by 2007 and to increasing the average age for first time drug use by 12 months by 2002 and by 36 months by 2007. CSAP programs also contribute to NDCS Goal 3, Objective 2, which is to *promote national adoption of drug-free workplace programs that emphasize a comprehensive program that includes: drug testing, education, prevention, and intervention*.

FY 2001 Agenda

The FY 2001 budget reflects CSAP's commitment in moving the substance abuse prevention field forward in the 21st century. The Center's program portfolio continues to build on the strengths of current and past cross-site KDA evaluations to identify effective practices while our TCE programs promote implementation of these best practices and address critical prevention capacity needs of States and communities. Within the budget request, CSAP will continue all ongoing KDA efforts, and add several new projects to our standing Community Initiated Intervention and Strengthening Families grants programs.

In the area of Knowledge Application, CSAP will continue the National Clearinghouse on Alcohol and Drug Information and public education efforts. CSAP will also begin efforts to develop a Prevention Decision Support System (PDSS) to disseminate evidence-based prevention intervention programs on the internet. CSAP's National Center for the Advancement of Prevention (NCAP) will continue its

identification of model programs through the National Registry of Effective Prevention Programs, and will disseminate effective programs through its 40-plus State of the Science Papers and Annual Review of the Status of Substance Abuse Prevention.

Within its Targeted Capacity program, CSAP will support approximately 14-16 new State Incentive Grants increasing the total of states receiving SIG awards to approximately 39-41 states. SAMHSA is proposing to modify the program to allow for matching funds from the States and to vary the size of the grant award according to State need. Because of significantly increased demand for services, we will also need to expand the six regional CAPTs that provide training and technical assistance in selecting and implementing best practices to the Drug Free Communities program, SIG States, and others.

KDA PROGRAM ACCOMPLISHMENT

Program Initiative: High Risk Youth Program

The High Risk Youth Cross-Site Evaluation analyzed the high risk youth portfolio including Female Adolescent Grants, High Risk Youth Demonstration grants and Replication grants to determine their broad-based effectiveness in preventing, delaying the onset or reducing substance abuse.

Goal 1: Assess the effectiveness of intervention strategies in decreasing the risk factors and increasing the protective factors related to substance abuse**.**

Findings:

- Analyses demonstrated clearly that overall protective factors decrease sharply and risk factors for substance abuse increase dramatically between the ages of 11 and 16.

- Structural equation models were developed using baseline data to delineate paths to substance abuse. The first and most potent is through the family; not only is family context related directly to reported levels of substance abuse, but it also contributes to peer factors related to substance use.

- A second path related to substance abuse includes a number of personal characteristics related to self-control, school efficacy and values. The third path includes contextual factors–school environment, community environment and neighborhood risk.

Goal 2: Assess the impact of CSAP funded programs in preventing or reducing substance abuse and related problem behaviors.

Findings:

- Preliminary results show clearly that relative to controls/comparisons, CSAP program intervention demonstrated statistically significant decreases in substance use in older youth.

- The younger cohort demonstrated little change due to the low basal rate.

Application:

- Data from the High Risk Youth Cross-Site baseline demonstrate the profound increase of risk to youth for substance use as a function of age; identify the nature of risk/protective factors; and provide clear suggestions concerning important aspects of effective prevention programs.

- This important work provides additional guidance regarding both the timing and content of effective prevention interventions.

- Additional analyses will be targeted to determine thresholds for effectiveness as well as differential effectiveness of similar interventions across different identifiable subgroups.

- Results from these analyses will provide crucial guidance to the field not only about the essential ingredients for effective interventions but also how these ingredients should be structured and phased for maximal effect with different populations.

KDA PROGRAM ACCOMPLISHMENT

Program/Initiatives: Predictor Variables Program

Goal:

The Predictor Variables Program study focused on four variables: social competence, self-regulation and control, school bonding and cognitive development, and parental involvement. The purpose of this study is to determine which interventions in these areas at which development stage work effectively in parenting and redirecting negative behaviors that are predictive of substance abuse. The ultimate aim is to promote emotional well-being in children at risk and to enhance their social and emotional development.

Findings:

- Preliminary finding show significant improvement in the intervention group relative to the control group in: improved parenting practices, increased family cohesion, increased family organization and decreased family conflict. Additionally, children in the intervention group showed significant reductions compared to the controls in aggressive disruptive behaviors and concentration problems.
- Interim results also reveal the rates of chewing tobacco were reduced from 2.6% to 0.5% in the intervention group, while the comparison group rates doubled from 1.1% to 2.3%.
- The use of alcohol was 4% lower in the intervention group compared to the control group.
- The rates of overall use of one or more drugs in the control group almost doubled from 6.8% to 12.4%, while this increase is less than half of a percentage point (0.4.%) in the intervention group.

Application:

- These data provide CSAP, States and local communities guidance to maximize the effectiveness of prevention interventions.
- Disseminating study findings is a key component of to facilitate the use of effective interventions.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Center for Substance Abuse Prevention

Mechanism Table

(Dollars in thousands)

	FY 1999 Actual		FY 2000 Pre-rescission Appropriation		FY 2000 Final Appropriation		FY 2001 Estimate	
Knowledge Development and Application:	**No.**	**Amt.**	**No.**	**Amt.**	**No.**	**Amt.**	**No.**	**Amt.**
Grants/Cooperative Agreements:								
Continuations	70	$31,305	166	$40,108	166	$39,785	30	$18,954
Competing:								
New	117	15,896	---	---	---	---	11	4,292
Renewal	---	---	---	---	---	---	---	---
Supplements:								
Administrative	---	1,500	---	---	---	---	---	---
Total, Grants/Cooperative Agree	187	48,701	166	40,108	166	39,785	41	23,246
Contracts	16	27,512	15	18,319	15	18,172	15	25,270
Technical Assistance	---	1,080	---	1,271	---	1,260	---	1,118
Review Costs	---	298	---	324	---	324	---	388
Total, Knowledge Development & Appl	**203**	**77,591**	**181**	**60,022**	**181**	**59,541**	**56**	**50,022**
Targeted Capacity Expansion:								
Grants/Cooperative Agreements:								
Continuations	25	63,101	70	63,141	70	63,141	60	39,201
Competing:								
New	50	11,065	5	14,090	5	14,090	19	42,176
Subtotal, Grants	75	74,166	75	77,231	75	77,231	79	81,377
Contracts	2	2,682	2	1,682	2	1,682	2	1,682
Technical Assistance	---	1,074	---	1,074	---	1,074	---	1,760
Review Costs	---	296	---	296	---	296	---	388
Total, TCE	**77**	**78,218**	**77**	**80,283**	**77**	**80,283**	**81**	**85,207**
High Risk Youth:								
Cooperative Agreements:								
Continuations	13	6,159	16	6,900	16	6,900	3	2,000
Competing:								
New	3	707	---	---	---	---	13	4,740
Subtotal, Cooperative Agreements	16	6,866	16	6,900	16	6,900	16	6,740
Contracts								
Technical Assistance	---	100	---	100	---	100	---	200
Review Costs	---	25	---	---	---	---	---	60
Total, High Risk Youth	**16**	**6,991**	**16**	**7,000**	**16**	**7,000**	**16**	**7,000**

C. Center for Substance Abuse Prevention
1. Knowledge Development and Application

	1999 Actual	2000 Pre-rescission Appropriation	2000 Final Appropriation	2001 Estimate	Increase or Decrease
BA	**$77,591,000**	**$60,022,000**	**$59,541,000**	**$50,022,000**	**-$9,519,000**

2001 Authorization

PHSA Section 501.....Indefinite

Purpose and Method of Operation

The two-fold goal of KDA efforts is to assure individuals have the information needed to understand the nature and consequences of substance abuse and State and community prevention practitioners have the knowledge, skills, tools, and assistance needed to implement science-based interventions proven effective in preventing, reducing, or delaying substance abuse and its associated problems.

CSAP's Knowledge Development (KD) programs identify, implement, and field-test through cross-site evaluation, prevention programs to determine their effectiveness with diverse populations in real-life environments. These KD grantees also create new curriculum packages providing practical, cost-effective materials useful with different cultural populations. These cross-site studies are using coordinated core measures and methods allowing the data to be pooled and analyzed across many different sites, thus increasing our knowledge of what works, for whom, and under what circumstances.

CSAP's Knowledge Application (KA) programs disseminate and foster implementation of best practices by States and community-based providers through the National Center for the Advancement of Prevention (NCAP), the Centers for the Application of Prevention Technology (CAPTs), the National Clearinghouse for Alcohol and Drug Abuse Information (NCADI), and the new Prevention Science Decision Support System (PDSS). The PDSS is a web-based expert system to provide immediate answers to prevention providers' questions along with downloadable prevention documents and materials. This web-based dissemination system is designed to be a more cost-effective method of meeting the increased number of requests at our clearinghouse, due in part to the White House's ONDCP media campaign.

Funding for the Knowledge Development and Application program during the last five years has been as follows:

	Funding	FTE
1996	$91,999,000	---
1997	$155,869,000	—
1998	$84,321,000	—
1999	$77,561,000	—
2000	$59,541,000	—

Rationale for the Budget Request

The FY 2001 budget request includes a total of $50,022,000 for CSAP's KDA portfolio. This is approximately $10 million below the FY 2000 appropriation. The requested level is sufficient to support all ongoing program efforts. Within the funds available, CSAP proposes to expand Community Initiated Interventions program ($2 million), Parenting and Family Strengthening ($2 million), and begin developing Prevention Decision Support System ($.4 million).

A. Knowledge Development

Identifying, testing, and evaluating prevention practices is the primary responsibility of CSAP's knowledge development program. CSAP's grantee programs are rigorously evaluated to determine effectiveness of researched-based prevention programs when implemented by community providers in real world settings with diverse populations. Cross-site and other evaluation findings identify best prevention practices to disseminate to the field; help to improve service delivery, and identify gaps in knowledge to be incorporated into CSAP's prevention programming. For example, a significant finding from CSAP's cross-site evaluation of the Community Partnership program and the High Risk Youth grant program showed unexpected gender differences in the results, namely, the reductions in drug use were stronger for males than for females. This clearly highlighted the need for gender-specific interventions which were then included within CSAP's Community Initiated Intervention program.

Since it's creation by Congress in FY 1996, CSAP has conducted seven KD cross-site grant programs. The first cohort of KD grants included ten 4-year grants awarded under the Developmental Predictor Variable grant program. The purpose of these grants was to discover the most effective prevention programs for different age groups of youth in urban or rural settings. Hence, grants were awarded to a matrix of urban and rural programs across four developmental periods. Each had to test comprehensive approaches to prevention including school, community and family-focused approaches. The evaluators in this cross-site represent some of the best prevention researchers and the findings will be unprecedented in the prevention field. Through collaboration on outcome measures and data collection and analysis strategies, SAMHSA programs are advancing the prevention field among coordinated partnerships.

Several other KD efforts such as the Children of Substance Abusing Parents (COSAPs) grant program; the Pregnant and Parenting Adolescents grant program; the early childhood Starting Early Starting Smart grant program, which is a collaborative with the Casey Family Program, will be completed by the end of FY 2000. Two programs, Community-Initiated program grants and the Family Strengthening grants, continue into FY 2001.

Initiated in FY 1999, the Community Initiated Interventions (CII) Grant Program responds to widely expressed need and support from the substance abuse prevention field. Establishment of this program was consistent with Congressional expectations that KDA results are relevant to local needs and current practice, readily integrated into prevention practice nationwide, and disseminated and adopted on the widest possible scale.

The CII program encourages each community applicant to determine the topic of study according to its needs and then test, adapt, refine and/or replicate proven research findings among different populations and in disparate community settings. As such, the CII program assures effective prevention strategies are relevant and appropriate to communities, by adapting, disseminating and applying programs meeting its unique needs. CSAP supports each community effort by providing expertise from field-tested prevention models identified in its High Risk Youth, Predictor Variable, and other knowledge development programs. Although CII projects are too new to yield preliminary results, the distribution of the topic areas funded clearly indicates the diverse needs identified by the communities and the breadth of proven prevention interventions that need to be further refined to suit local problems and populations. The FY 2001 request includes $2.0 million for new grants in this area.

The Parenting and Family Strengthening Intervention Program is also continued in FY 2001, with $2.0 million to be awarded in new grants. CSAP's Prevention Enhancement Protocol System has completed a review of the family-focused research literature and determined that only four approaches meet the highest level of evidence for effectiveness: 1) behavioral parent training, 2) family skills training, 3) family therapy, and 4) in-home family support. A meta-analysis of all family programs with results concluded that these family-based prevention programs are 9 times more powerful in making positive changes in youth helpful in reducing later drug use than are school-based programs. Hence, field-testing and helping communities to select the very best family strengthening program must be an essential part of any comprehensive prevention program. Ninety-five community agencies received funding in September, 1999. Through a carefully designed naturalistic study, these 95 communities are being supported to use one of 28 of the best parenting and family programs addressing local needs. These 28 programs represent the best of over 70 parenting and family programs reviewed by a panel of experts.

Grantees are being trained, during the spring of 2000, in community and organizational readiness to determine the best parenting programs to implement and how to implement these programs with integrity. This program will increase local community capacity to deliver best practices in effective parenting and family programs while documenting the decision-making processes for selecting and testing effective interventions impacting target families.

Like the Community Initiated Interventions, Family Strengthening programs target local community needs and will be integrated into prevention practice and disseminated on the widest possible scale.

B. Knowledge Application

Disseminating and promoting best prevention practices learned through CSAP's knowledge development programs is the responsibility of CSAP's Knowledge Application (KA) programs. As such, CSAP's KA programs further develop and disseminate the information, materials, and tools needed by the public and prevention practitioners to expand the use of cutting edge information and best practice models in the Nation's communities. CSAP program findings are synthesized by CSAP's National Center for the Advancement of Prevention (NCAP) and disseminated to the field through a variety of application mechanisms including the National Registry of Effective Prevention Programs (NREPP) and the Prevention Decision Support System (PDSS). CSAP's application programs work in tandem with CSAP's SIG and CAPT programs to help build prevention capacity at the State and local levels. Program-generated information and materials are also widely disseminated by the National Clearinghouse for Alcohol and Drug Information (NCADI) and used as the basis for nation-wide prevention education campaigns such as *Girl Power!* In 2001, CSAP will continue all major knowledge application programs including:

The ***National Center for the Advancement of Prevention (NCAP)*** synthesizes prevention research and evaluation findings; develops new prevention knowledge and tools; examines trends and patterns of substance use and precursors of use; translates scientific and practice-based knowledge into practical and timely prevention products for States and the field; and fosters the adoption and application of science-based prevention practices. Among NCAP products are Technical Reports on such topics as *Alternative Activities and Alternatives Programs in Youth-Oriented Prevention* and *Strategies for Reducing Sales of Tobacco Products to Minors*; Implementation Guides on *Effective Community Mobilization* and *Tobacco Outlet Inspections*; and Resource Papers such as the AESOP *Overview of the Science and Models of Prevention*. Products have been used to bolster CSAP training and technical assistance activities, to improve CAPT efforts and to change/improve program strategies and effectiveness in the field.

The ***National Clearinghouse for Alcohol and Drug Information (NCADI)*** is the largest information clearinghouse in the country for alcohol and drug information. It responds to about 200,000 information requests annually and distributes over one million free or at-cost Federal publications, audiotapes, and videotapes per month. The current level of demand (as of October 1999) for NCADI services during a typical month is reflected in the following profile: 33,316 requests/month; 59 percent of inquiries are made by phone; 3 percent by mail; 30 percent by e-mail; and 2 percent by fax/in-person. NCADI has been the national resource for consumer materials for ONDCP's National Youth Anti-Drug Media Campaign that was launched in mid 1998. Infrastructure support includes a toll-free number, extended hour phone coverage, and provision of bulk quantities of materials (1,050 tons in 1998) to respond to campaign-generated requests. After the first two weeks of the campaign, the NCADI contract experienced a 121 percent increase in caller volume as a result of the media advertising in 75 media markets. Hits to the NCADI website, Prevline, now exceed 4 million per month; hits increased from 13.3 million in 1997 to 34.5 million in 1998. During one day NCADI answered 4200 telephone calls stimulated by a Sunday *Parade*

Magazine article. Historical records indicate that caller volume increases steadily each year regardless of broad-based media efforts.

The ***Prevention Decision Support System (PDSS)*** is an emerging CSAP program designed to meet the needs of the practitioner, or "end-user" by increasing electronic access to best practices. Computer software will integrate and provide prevention practitioners with immediate access to local needs assessment data, logic models, and an expert system to help select the best practices to meet local needs. The PDSS will be equipped to provide on-line, real-time information, training and technical assistance to its customers relative to needs assessments, logic models, program selection and implementation, community resources, resource development, and report writing. It will also include a complete Management Information System, outcome measures and data analysis package. The system will be compatible with personal computers and will be distributed on CD-ROMs. CSAP began preliminary work on the PDSS during FY 1999; a prototype should be completed by mid-2000. In FY 2001, CSAP's will focus on fully developing the modules that comprise the core of PDSS services.

The ***National Registry for Effective Prevention Programs (NREPP)***. CSAP's NREPP is an ongoing repository of guidance to the substance abuse prevention field. The NREPP contains implementation and outcome information on substance abuse prevention intervention projects sponsored by all Federal agencies, State governments, foundations, and corporations. Publicly available on the world wide web at http://www.preventionregistry.org/trial.htm,, NREPP provides opportunities for field nominations of standardized programs. These programs must show evidence of reducing risk factors or increasing protective factors pertaining to substance abuse to be considered in the registry. Nominations may be made for new, innovative programs as well as for adaptations or replications of established or science-based prevention models. Teams of trained evaluators review programs based on 15 criteria including: theory, fidelity of interventions, process evaluation quality, sampling strategy and implementation, attrition, outcomes measures, missing data, outcome data collection, analysis, other plausible threats to validity, integrity, utility, replications, dissemination capability, cultural- and age- appropriateness. This review process serves to identify a subset of "model" prevention efforts and rates their evidence using a five star system.

CSAP promotes selected models from the NREPP in three ways: 1) by supporting the development of program materials for dissemination, 2) by connecting program developers with organizations able to help in the dissemination efforts, and 3) by promoting model programs nationally through CSAP's State Incentive Grant recipients and regional Centers for the Application of Prevention Technologies.

C. Center for Substance Abuse Prevention
2. Targeted Capacity Expansion

	1999 Actual	2000 Pre-rescission Appropriation	2000 Final Appropriation	2001 Estimate	Increase or Decrease
BA	**$78,218,000**	**$80,283,000**	**$80,283,000**	**$85,207,000**	**+$4,924,000**

2001 Authorization
PHSA Section 501.....Indefinite

Purpose and Method of Operation

CSAP's Targeted Capacity Expansion (TCE) programs help States and communities address current and specific gaps in availability of substance abuse prevention services and improve the quality of prevention services provided. The TCE programs are the major efforts CSAP uses to promote science-based "best practices" in State and community prevention service systems. These programs address CSAP's GPRA Goal 3: Assure services availability/meet targeted needs; and GPRA Goal 2: Promote the adoption of best practices. TCE programs also support National Drug Control Strategy Goals 1 and 3.

CSAP's Targeted Capacity program is comprised of three major efforts:

1. State Incentive Grants

Data from the 1995 National Household Survey on Drug Abuse showed disturbing increases in drug use among youth, particularly in marijuana use, which prompted a DHHS review of substance abuse prevention services nationwide. The review found an inefficient system characterized, at the State level, by: 1) uncoordinated and fragmented use of resources, knowledge, and information relating to what works in prevention; 2) lack of a systematic evaluation of programs and practices to identify effective, scientifically derived approaches; and 3) lack of a systematic approach for disseminating these research findings to improve prevention services.

The State Incentive Grant program was established to respond to these findings. The program's two key goals were to: effect changes at the State level by ensuring that States better coordinate the allocation of disparate substance abuse prevention funding streams; and to effect changes in the availability and quality of State prevention services by funding critical, unmet prevention needs and ensuring new programs use state-of-the-art prevention practices. Under the SIG program, States award 85% of the funds to subrecipient communities to implement new or expanded prevention programs that employ best prevention practices.

The SIG Program design married the results of CSAP's High Risk Youth (HRY), Community Partnership and Community Coalitions Demonstration Grants. It helps States and communities to implement the best practices identified to date by the HRY and other CSAP demonstrations programs while using the Community Partnership model as the delivery mechanism. It is important to note that at least three of the highly effective prevention models identified by CSAP's High Risk Youth programs are identified as among the top 10 most implemented programs by SIG subrecipients.

By the end of FY 2000, a total of 25 SIGs awards will have been made to States and the District of Columbia. States are funding between 20 and 30 subrecipient communities each. Depending on the State's prevention plan, these community subrecipients can be counties, cities and/or towns, community coalitions or partnerships, Indian Reservations, Community-School Districts and other jurisdictional arrangements appropriate to the particular State. Each of these subrecipient communities in turn support two or more science based prevention programs in their community. In the State of Washington, for example, each community subrecipient supports up to 4 targeted prevention programs at the local level. In another case, Colorado has used existing infrastructure -- Community School Districts -- as the jurisdictional entity to receive its SIG funds. As a result, each of the Colorado School Districts then funds 2 to 4 individual schools, or clusters of schools to implement prevention programs. By using existing infrastructure, States have been able to put into place a larger number of science-based prevention programs.

It is estimated that approximately 49 percent of the subrecipients are community-based organizations; 23 percent are coalitions and partnerships, 22 percent are local governments, and 6 percent are schools and school districts. These organizations are using SIG dollars to increase services capacity by more than 2,500 science-based prevention programs estimated to reach over 1 million participants by FY 2001.

Estimated Number of Subrecipients, Prevention Programs, and Individuals Served through SIG Funding FY 1997 - 2001

	1997	**1998**	**1999**	**2000**	**2001**
Number of States/Year	5	14	2	4	14-16
Number of States (Cumulative totals)	5	19	21	25	39-41
Subrecipient Organizations (Cumulative totals)	125	475	525	625	1,025
Prevention Programs Supported (Cumulative totals)	312	1,187	1,312	1,562	2,562
Number of Participants* (Cumulative totals)	138,437	525,841	581,216	691,966	1,134,966

*based on estimated 443 participants per program

The State Incentive Grants are impacting substance abuse prevention in the States at three levels: the State level, the community level, and the project level where prevention services are delivered. Major outcomes to date include:

- Promoting use of best practices by increased science-based programs in communities. Over 60 percent of all current SIG-funded community programs are reported or documented as science-based. For example, in Illinois, as a result of SIG changes their SAPT Block Grant recipients (over 100) must incorporate evidence-based prevention in their programming.

- Expanding prevention services capacity at the community level. More than 1300 new and/or expanded prevention programs will have been put into place by the 21 SIGS awarded through the end of FY 1999. More than 500,000 individuals will have improved access to quality prevention programs.

- Reducing risk and drug use. Program level data available to date show that SIG funded programs have been effective in reducing substance abuse in the communities where implemented. For example, Kansas reduced drug-related violence as a result of a SIG-sponsored community coalition.

- Leveraging of SIG funds to increase State service capacity in prevention. Through the involvement of State Governors, SIG States have successfully leveraged other prevention funds from public/private sector sources through matching funds-in some cases, up to 10 times the grant amount. Governors have conducted Statewide inventories of prevention resources; identified and leveraged local matching funds; and merged resources from United Way, Safe and Drug Free Schools, State and local agency grants, and private entities. Moreover, they have integrated the 20 percent SAPT Block Grant set-aside funds into their SIG prevention plans. Kentucky, for example, has added approximately $1.5 million in state funds for infrastructure supporting science-based prevention programs and Kentucky communities have leveraged $1.2 million each year to match the $2.5 million in SIG funds.

- Increasing State level coordination and collaboration. Governors have effectively coordinated their prevention resources to create a more comprehensive, multi-agency system of prevention service delivery. They have increased state-wide collaborative approaches for responding to the specific problems of youth drug use and created Governor's Councils on Substance Abuse Prevention to guide youth-focused prevention strategies. Illinois, North Carolina and Massachusetts have used the SIG opportunity as a vehicle for State agencies to build and strengthen new collaborations in prevention programming. Data from 11 SIG states indicate the average amount of funds coordinated due to SIG efforts approximates $28.2 million.

- Optimizing use of State and Federal prevention dollars for youth services. The SIG program has heightened State awareness and response to the role prevention plays in reducing the demand for drugs among youth. In Oregon, as a direct result of the SIG, the State now includes a separate line item for substance abuse prevention, giving drug prevention a higher priority status. SIG States are taking full

advantage of the SIG program, and nearly all have committed to integrating their Block Grant monies into their strategic plans as a result of SIG. In Vermont, SIG funding has prompted changes in the way SAPT block grant funds have been allocated, especially to support science-based prevention programs.

2. Centers for the Application of Prevention Technologies

The National Centers for the Application of Prevention Technologies (CAPTs) were established in FY 1998 as essential partners to the State Incentive Grant Program (SIG), intended to provide the necessary training and technical assistance to SIGs and their subrecipient grantees. The centers increase the recipients' knowledge about effective prevention strategies, principles and programs and identify and implement the best practices for local real-life settings. This is extremely important to assure the best outcomes for the people receiving prevention services.

The CAPTS, located in six regional sites, comprise a major national resource supporting the widespread use of scientifically sound and effective substance abuse prevention interventions. Demand for CAPT targeted capacity building services has been significantly increased. In FY 1998, the CAPT's served 19 SIGs. By FY 1999 they served 21 SIGs, 525 SIG sub-grantees, 224 Drug Free Community grantees funded by ONDCP and OJJDP, trained many Safe and Drug Free School grantees funded by the Department of Education, and participated in the U.S.-Mexico Border Initiative. The rate of requested technical assistance and its successful delivery by the CAPTs in the SIG States had increased 400% by the close of FY 1999. Similarly, there was an increase in excess of 200% in training of science-based prevention to the SIG States and their sub-recipients. In FY 2000, the CAPTs are projected to serve: 25 SIGs, 625 SIG sub-grantees, all 25 non-SIG State programs, 300 ONDCP Drug Free Community grantees, 95 Family Strengthening grantees, 40 Substance Abuse/HIV Prevention grantees, and many Tribes and U.S. Territories/Jurisdictions in the Pacific and Caribbean.

The success of the CAPTs has increased the interest in and use of science-based prevention in States and communities. Participants in the first National Prevention Congress, convened by CSAP in March 1999, confirmed this interest by recommending enhancement of the nation's technical assistance and training capacity to support science-based prevention program implementation and strategic planning as a cross-cutting theme critical to the success of the National Prevention System. The CAPTs meet this need; no other entity exists to provide technical assistance and training services on a national scale. Their accomplishments include:

- During FY 1999, CAPTs provided technical assistance to virtually all the SIG sub-recipients to help them identify and apply the latest research-based knowledge and effective methods of substance abuse prevention programs, practices, and policies.

- In FY 1999, the CAPTs delivered their services in collaboration with agencies responsible for substance abuse prevention services in all SIGs and at least 94 percent of sub-recipients.

- The CAPTs also provided requested training and technical assistance services to the remaining 29 non-SIG States as well as to all U.S. Territorial governments and about 20 percent of the Native American Tribal agencies. Further, the CAPTs provided services to approximately 20,000 prevention programs and practitioners.

3. HIV/AIDS Prevention

Citing a chronic and overwhelmingly disproportionate burden of HIV/AIDS on communities of color, in October 1998, President Clinton outlined a new comprehensive initiative. It included unprecedented efforts to improve the Nation's effectiveness in preventing and treating HIV/AIDS in the African American community and other communities of color. The Congressional Black Caucus (CBC) called for a public health emergency, predicated on statistics demonstrating the disproportionate impact of HIV disease in the African American community.

In FY 1999, CSAP launched a new $13.5 million, multi-component, Substance Abuse Prevention and HIV Prevention Initiative designed to address the well-documented nexus between these two devastating public health problems. The Initiative addresses the need to integrate prior discrete and separate prevention services to maximize their effectiveness, improve client/consumer outcomes, and prevent, delay or reduce transmission of HIV associated with substance abuse behaviors. CSAP placed emphasis within its program on populations experiencing high incidence of substance abuse/HIV problems, including African American youth and women of color.

Under this program, forty-eight grants were awarded in September, 1999. While they are currently too new for preliminary findings, the program is expected to strengthen integration of HIV and substance abuse prevention at the local level, increase the provision of integrated prevention services to African-American and other racial/ethnic youth and women, and identify best practices for further application in the field.

Funding for the Targeted Capacity Expansion program for the last five years is as follows:

	Funding	FTE
1996	—	---
1997	—	---
1998	$6,679,000	—
1999	$78,218,000	—
2000	$80,283,000	—

Rationale for the Budget Request

The FY 2001 budget requests an increase of nearly $5 million in new funds for the Targeted Capacity Expansion program. CSAP will award 14 to 16 new SIG awards in FY 2001 to reach over eighty percent of the States (cumulatively) and facilitate critical prevention system and practice improvements. CAPT

training capacity will be enhanced and HIV programs will be continued. Other mechanisms for the support of State prevention infrastructure needs will be explored as well as consideration in developing future policies to include a matching requirement from the State.

CSAP is developing a review process of options for SIG funding based on State specific data from the expanded National Household Survey on Drug Abuse, available in August, 2000. In addition, changes in the program structure based on qualitative and process data gathered to date will be considered. The first modification considered requires State matching funds. It is expected a matching requirement ensures a greater commitment by the State to sustain long term prevention funding. An analysis of states' total prevention expenditures for FY 1995 indicates a wide range in the level of State Support. In 23 States, State revenues accounted for less than 10% of prevention expenditures; at least 15 of these States spent no State funds for prevention at all. The second modification considered permits adjustments in the total amount of State SIG awards, based on criteria such as percentage of state population under 18 years of age and State-specific results of the National Household Survey on Drug Abuse.

C. Center for Substance Abuse Prevention
3. High Risk Youth

	1999 Actual	2000 Pre-rescission Appropriation	2000 Final Appropriation	2001 Estimate	Increase or Decrease
BA	**$6,991,000**	**$7,000,000**	**$7,000,000**	**$7,000,000**	**—**

2001 Authorization
PHSA Section 501.....Indefinite

Purpose and Method of Operation

The initial High Risk Youth Grant Program, started in 1987, is CSAP's first knowledge development activity. The goal of this program is to prevent substance abuse and associated precursors (e.g, aggression, violence, depression, and school drop-out) in high risk youth. Many of the grants funded over the years test the most effective models of prevention with ethnic youth. Recently, the emphasis of this High Risk Youth Program has been focused primarily on supporting the National Drug Control Strategy Goal to increase the number of mentors and adults helping to educate youth about the dangers of drug use.

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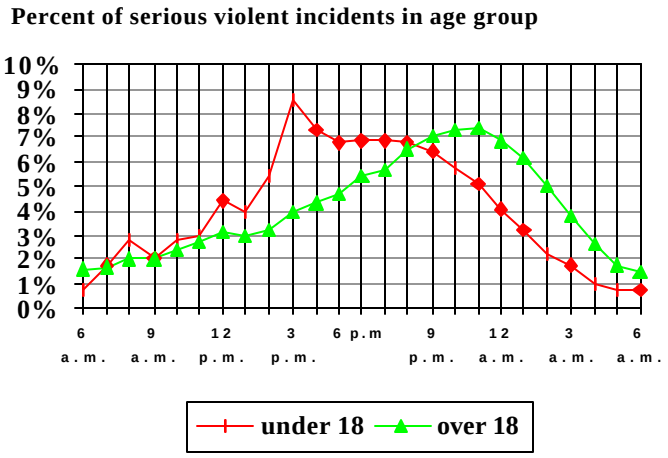
In FY 1998, CSAP initiated Project Youth Connect (PYC), mentoring/ advocacy models focusing on youth ages 9 -15 and their families. Building upon knowledge gained from previous CSAP-supported mentoring programs as well as the prevention literature, the PYC projects are designed to prevent and or reduce substance abuse or delay its onset, by improving school bonding and academic performance and by improving life management skills and family bonding and functioning.

CSAP's High Risk Youth Grant Program has demonstrated a number of positive youth development approaches proven effective in reducing problem behaviors in high risk youth. CSAP is disseminating the most effective exemplary High Risk Youth programs through their *Here's Proof Prevention Works* kit and publications. Examples of these exemplary programs are Smart Leaders and FAN Club programs and Cross Ages intergenerational mentoring program. Both of these exemplary model programs involve a type of mentoring. Positive youth development activities also include tutoring or assistance with school projects, leadership training, recreational and vocational training, and community service. A major venue for positive youth development activities is after school or summer school programs, where youth participate in recreational activities, performing arts, or community services. Positive youth development programs may be based in any number of community settings including churches and other faith-based organizations, recreational centers, and senior centers. The most successful after school programs also employ life skills curriculum and community service.

Research conducted by the Federal Bureau of Investigation between 1991 - 1996 reveals the critical time periods when youth are most vulnerable to engaging in violent crime, peaking at 3 p.m. The following graph clearly demonstrates the need for more pro-social activities for minors, particularly during after school hours. Most needed are adult supervised prevention interventions provided during these high risk hours. If youth are engaged in activities geared to positive development, it is anticipated communities will realize substantial reductions in both violence and substance abuse.

Project Youth Connect. These High Risk Youth projects support a diverse array of mentoring models, but all employ trained mentors committed to intensive periods of involvement with youth. The intent is to determine whether intensive involvement with formally trained mentor/advocates is more likely to positively impact young people at an earlier stage. The ultimate goal, however, is to link the youth with a volunteer mentor from the community who can remain a part of the youth's life after he/she is no longer in the program. After 6 months of intensive interaction with the youth, the professional mentor is instrumental in linking the youth with a community volunteer. During the ensuing six months, the youth interacts with both the professional and the volunteer mentor, finally transitioning into a one-on-one relationship with the volunteer.



It is expected new HRY interventions will be effective in reducing substance abuse and related violence, as well as in improving community attitudes toward youth and enhancing the system of support available to youth and their families. In addition to alcohol, tobacco, and illicit drug use and attitudes, information on the following is being collected: 1) improved school bonding, grades and attendance (e.g., school bonding scale of the National Youth Survey); 2) improved parent/care giver attachment and parental supervision (11 items from the Office of Juvenile Justice and Delinquency Prevention's (OJJDP) Causes and Correlates Study); 3) improved life management skills such as peer refusal, problem solving, self efficacy, cultural pride and peer relations. Grants under this program were awarded in September, 1998, with implementation in all sites started by summer, 1999. The programs are too new to supply outcome data.

Study of Risk Factors for Drug Use During Adolescence. Recently, results from the High Risk Youth Program cross-site study, sampling over 10,500 youth participating in recent HRY grants, revealed the factors either placing these youth at risk or protecting them. The major risk and protective precursors of tobacco, alcohol, and drug use in youth were profiled by age. The study revealed protective factors decrease systematically during the critical middle school years (ages 11 - 15). These data explain why programs specifically targeted to middle school youth focusing on increasing protective factors such as family and school bonding are the most effective in preventing tobacco, alcohol, and illicit drug use. Hence, a

window of opportunity for prevention of tobacco, alcohol, and drug use and is prior to age 15. However, older youth and adults also need prevention messages and supportive environments. These findings suggest if a youth does not initiate substance use by 15 years of age, the risk is much lower of ever becoming an addict or alcoholic. When targeting scarce prevention resources, we have chosen to focus primarily on programs for high risk youth in middle school or earlier.

Pathways to Drug Abuse Study. CSAP also conducted an analysis of reasons why youth use tobacco, alcohol, and drugs. Using a sample of 8,500 high risk youth, we determined the strongest predictor of later drug use is association with friends who use drugs. However, the major predictor of a youth who will associate with friends who abuse drugs is the family's norms supporting tobacco, alcohol or drug use, little parental supervision and monitoring of the teenager's activities, and little family support and care. The study also showed by increasing protective factors such as family attachment and supervision, effective parenting, school pride and attachment, and by improving behavioral management through life and anger management skills ultimately there will be a decrease in the likelihood of youth substance abuse and violent behavior. Girls were found to be more strongly influenced by their relationships to their families. Boys were influenced somewhat more than girls by the community tobacco, alcohol, and illicit drug norms and environment. The precursors for substance use were also analyzed for each of the ethnic groups to help prevention providers better target the most effective approaches of prevention for these youth.

High Risk Youth Program Outcome Study. The results of the pre- and post-tests using the same Core Measures Instrument, revealed the grant program had produced reductions in substance abuse in youth participating in the program. It documents statistically significant reductions in 30 day substance use, cigarette use, alcohol use, and marijuana use, although not inhalant use, for 12 - 17 year olds participating in the High Risk Youth grants.

Funding for the High Risk Youth program during the last five years has been as follows:

	Funding	FTE
1996	---	—
1997	—	---
1998	$6,000,000	—
1999	$6,991,000	—
2000	$7,000,000	—

Rationale for the Budget Request

The FY 2001 budget requests $7.0 million for the High Risk Youth program, the same as the FY 2000 appropriation. This level is sufficient to continue all ongoing program efforts and allow CSAP to: 1) focus on an even higher risk group of youth, including children of alcohol and drug abusers, siblings of youth in the juvenile justice system, girls who have dropped out of school, and homeless youth, and 2) address latch-key youth who are in need of adult supervision during high risk hours for tobacco, alcohol, and drug use (i.e., after school).

Like the KDA Community-initiated Grant Program, the High Risk Youth Program will permit applicants to determine the most effective prevention approach for the targeted high risk youth population in their community. Programs must select the most appropriate approach from the list of exemplary prevention programs in CSAP's National Registry of Effective Prevention Programs. The seven exemplary High Risk Youth Program Models currently being disseminated through the publication, *Here's Proof Prevention Works* (CSAP, 1999) will be recommended for implementation. They will be asked to field-test them with new high risk youth populations and to develop appropriate materials (e. g., written curriculum, videos, and evaluation instruments) for dissemination of the program to other similar target populations (rural youth, American Indian youth, juvenile justice youth, etc.).

C. Center for Substance Abuse Prevention
4. Substance Abuse Prevention and Treatment Block Grant (SAPTBG)

	1999 Actual	2000 Pre-rescission Appropriation	2000 Final Appropriation	2001 Estimate	Increase or Decrease
BA	$301,150,000	$304,000,000	$304,000,000	$309,890,000	+$5,890,000

Purpose and Method of Operation

CSAP administers the primary prevention component of the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) as it applies to all 50 States, 10 jurisdictions, and one Indian Tribe. The Block Grant 20 percent prevention set-aside program is one of the largest substance abuse prevention programs funded by the Federal government. Twenty percent of the SAPTBG funds allocated to States according to legislative formula must be spent on substance abuse primary prevention services. States vary widely in the extensiveness and scope of their prevention services. While some States depend entirely on the 20 percent set-aside to support their activities, others use these funds to fill gaps and enhance existing programs' impact.

Specific examples of the outcomes from States' use of these funds are:

- The Massachusetts Bureau of Substance Abuse Services spent approximately $7 million to support a range of alcohol, tobacco and other drug prevention services for groups at risk. The substance abuse prevention program includes ten regional centers serving as a network for technical assistance, information dissemination, and support to community groups and organizations, including coalitions, schools, youth agencies, health programs, and faith communities. Special emphasis was given to programs serving high risk youth addressing youth development and peer leadership, student assistance, court diversion, and street outreach in Boston.

- The Missouri Division of Alcohol and Drug Abuse focused its $4.8 million in substance abuse prevention funds on a network of 12 regional Community 2000 Support Centers assisting in developint and maintaining over 140 community coalitions. The Support Centers assisted the coalitions with needs assessment, planning, evaluation and training.

- The Illinois Bureau of Substance Abuse Prevention directed the expenditures of its $12.2 million in substance abuse prevention funds through a strategic planning process for prevention developing prevention goals and objectives with specific outcomes. Prevention goals are to 1) increase knowledge and involvement of stakeholders, 2) provide highest quality services, and 3) develop an

effective service delivery system. Key to this effort is the objective to provide prevention services for all residents, with a goal of reducing substance abuse by three percent each year.

- Montana's Chemical Dependency Bureau guided the use of $1.1 million in substance abuse prevention funds with a carefully executed, statewide needs assessment process, using the *Communities That Care* model. Working through the 12 units of the Montana Association of Counties, lead prevention programs were designated in each unit to develop capacities for training, information dissemination, needs assessment, and planning. Two measurable, statewide substance abuse prevention outcomes were set: 1) to decrease the percentage of youth who have their first alcoholic drink, and 2) to decrease the percentage of youth who smoke cigarettes on ten or more days a month.

- States have progressed in their ability to comply with the Synar Amendment. In the past year, State authorities have made significant progress in developing enforcement infrastructures to reduce the sale of tobacco products to minors. The median noncompliance rate of sales to minors as reported by the States in 1999 was 21.6 percent. This is a significant reduction from the median rate of 40.1 percent in 1997 and pre-1997 studies that found noncompliance rates ranging from 60 to 90 percent. Twenty-one States reported 1999 noncompliance rates of 20 percent or less. Three States reported noncompliance rates of under 10 percent. All States have plans in place to ensure their noncompliance rate is 20 percent or less by the close of FY 2002.

Funding for the Substance Abuse Prevention Block Grant program during the last five years has been as follows:

	Funding	FTE
1996	$246,821,000	10
1997	$248,920,000	10
1998	$248,920,000	10
1999	$301,150,000	10
2000	$304,000,000	12

Rationale for the budget Request

A total of five percent of the Block Grant annual appropriation is required to be set-aside for Federal data collection, evaluation of programs supported by the Block Grant, and technical assistance. Of this five percent, 20% is available for prevention support. Set aside funds are used to conduct and analyze data from needs assessment studies; to improve program planning, development and services delivery; to provide on site technical assistance, and for other services to enable State agencies to maximize the effectiveness of their investment in prevention.

CSAP will continue to use their portion of the set-aside for improvement of State prevention systems. CSAP uses the funds to develop and implement advanced prevention methodology for all components of State prevention systems including systems for data collection and performance measurement. Specific examples of activities to be continued in FY2001 include:

State Needs Assessment: This successful CSAP Program has supported 30 States over the past five years. It assists States in targeting their prevention programming and resource allocation by providing scientifically sound, quantitative data on specific populations and localities while identifying distribution of particular risk factors, incidence, and prevalence at the State and local levels. It also provides an inter-State forum for the exchange of effective needs assessments methodologies, technologies, and applications. States are required to conduct a core set of studies, including school-based, archival, and community resource assessments. States may also propose State specific studies reflecting unique State concerns, e.g., needs related to Native American and homeless populations. This support has resulted in an increase States reporting needs assessment results in their Block Grant applications. The data have been invaluable. For example:

- The results of a CSAP-funded middle school survey showed the need for targeting more prevention programs to youth during their middle school years, a transition from childhood to adolescence. As a consequence, New Jersey launched the "Systematic Drug Abuse Initiative: Peers Leading Peers in the War Against Drugs" which includes 50 middle schools each year.

- In Texas, information from CSAP's needs assessment determined which populations were particularly underserved. These results are being used to justify program services for those under served populations, specifically targeting Hispanics and college students.

- In Utah, the Department of Education recognized the importance of the prevention needs assessment data and used it for allocating Drug-Free Schools funds.

***Technical Assistance and Site Visits to the States*:** CSAP has provided TA activities to more than 45 States and jurisdictions to support their substance abuse prevention systems. TA has been provided on-site, by telephone, and in multi-State formats. Primary areas of assistance provided include: planning (e.g., developing a State-wide plan, developing outcome measures), workforce development and staff training (e.g., developing a plan for credentialing and certification), overall system and management issues, monitoring, needs assessment (e.g., risk and protective factors and results mapping), and program evaluation.

CSAP is developing revised guides for conducting technical reviews of the States' management and implementation of the requirements and conditions of the SAPTBG, including implementation of Synar regulations. CSAP will continue to provide support for all States' efforts and monitor their progress to ensure they are making every effort to reduce illegal sales of tobacco products to minors as mandated by the Synar Amendment.

CSAP's technical assistance to States has received a 94% satisfactory rating from our State customers. Moreover, 100% of States have received technical assistance in implementing the Synar program, up from 20% in FY97. Synar technical assistance includes but is not limited to the provision of help in developing retailer lists, identifying outlets, developing merchant education programs, providing assistance with technological interventions, community mobilization programs, and improving collaboration between state and local authorities responsible for complying with Synar requirements.

Performance Measurement: In 1997, twenty-seven states convened to discuss prevention performance outcome measures. Results of that meeting, CSAP mission measures and SIG core measures led to the FY 2000 SAPT block grant now including optional forms, approved by OMB, that States can use to voluntary report on five outcome measures for Block Grant funded programs. CSAP is working with interested States to reach agreement and finalize SAPT Block Grant priority outcome indicators, identify obstacles to State reporting and mechanisms for overcoming these barriers, and agree to reasonable time lines for national implementation of Block Grant outcome reporting.

Minimum Data Set: A Minimum Data Set (MDS) initiative has been underway to support States' collection of data on the number and types of prevention services provided and populations served. States use common data items, common definitions, and common methods of data collection. CSAP has supported the development and implementation of a PC based software system and the technical assistance related to training and installation. More advanced Phase I software is being developed. As of July, 1999, twenty states are using or implementing MDSI. MDSI allows the provider, the substate entity and the state as a whole to identify the types of activities being provided to a variety of population groups, e.g., demographic groups, high risk populations, providers, etc. States then use the results to more effectively target and allocate resources and improve State planning for prevention programs. Two examples of MDSI States include:

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- Colorado has developed their MDSI system to collect demographic, program, and activity information on all of their service providers. The State has also developed a program evaluation system to monitor provider planning and implementation efforts. Using these two systems, Colorado now has the ability to plan, design, and develop program services and strategies that meet the prevention needs of the State.

- Pennsylvania has also developed their MDSI system to monitor local planning, programming, and service provision. Based on the MDSI data collection effort, Pennsylvania officials developed future program goals in terms of planning prevention activities, the clientele to be served, and defining effective strategies.

D. Center for Substance Abuse Treatment
Overview

	1999 Actual	2000 Pre-rescission Appropriation	2000 Final Appropriation	2001 Estimate	Increase or Decrease
BA					
KD&A	$115,297,000	$100,259,000	$100,259,000	$95,259,000	-$5,000,000
TCE	55,089,000	114,307,000	114,307,000	163,161,000	+48,854,000
SAPT Blk Grant . . .	1,585,000,000	1,600,000,000	1,600,000,000	1,631,000,000	+31,000,000
Total	$1,755,386,000	$1,814,566,000	$1,814,566,000	$1,889,420,000	+$74,854,000

Substance abuse treatment has been conclusively shown to be effective in reducing drug use as well as the attendant social costs (health care, criminal justice, homelessness, etc.). CSAT's National Treatment Improvement Evaluation Study demonstrated a 50 percent decrease in drug and alcohol use one year after completing treatment. The Drug Abuse Treatment Outcomes Study corroborated the findings from the CSAT study, and the Services Research Outcomes Study also showed significant decreases in illicit drug use five years following treatment.

A new initiative was undertaken in 1999 to improve the availability, accessibility and quality of substance abuse treatment services nationwide. This initiative, ***Changing the Conversation: The National Plan to Improve Substance Abuse Treatment*** **(NTP)**, involves a comprehensive analysis of five specific areas related to funding for and access to service delivery systems, public attitudes and beliefs, and best practices and treatment methods for addressing substance abuse and addictions. Those five areas or domains are: 1) closing the treatment gap; 2) reducing stigma and changing attitudes; 3) improving and strengthening treatment systems; 4) connecting services and research; and, 5) addressing workforce issues. A series of stakeholder meetings were held, bringing research and treatment professionals together, and six public hearings held nationwide received testimony from more than 420 witnesses. This effort will lead to a comprehensive report reflective of findings and recommendations. The report will be the foundation to guide subsequent program planning for CSAT and future action for the treatment field, and will be shared with other federal entities involved with substance abuse and addiction issues. While the final report is not expected until early this summer, CSAT has already begun to address preliminary findings from the NTP in its activities and programs.

While treatment is known to be effective, a gap in the availability of treatment continues to exist. The substance abuse treatment field typically defines the treatment gap in one of three ways:

1) ***availability and demand:*** The amount of services available related to the prevalence of addiction disorders and the number of individuals who identify themselves as interested in entering treatment;

2) ***access and demand:*** The services utilized in relation to penetration rates of services (geographic and other availability of services), actual prevalence of disorders, and the number of individuals who identify themselves as interested in entering treatment;

3) ***funding and demand:*** The dollars actually allocated by service type in relation to the prevalence of addiction disorders and the number of individuals who utilize services.

Closing the treatment gap is an issue of ensuring that people in need of treatment receive it; that sufficient resources are available to deliver the quantity of services needed; and that the types and levels of care needed are available. Closing the treatment gap is especially important to those who could benefit from early intervention and immediate treatment, in order to prevent the development of long term drug and alcohol problems. The Center for Substance Abuse Treatment has adopted the National Drug Control Strategy model for the treatment gap as well as the health and social costs associated with drug use. The targets established by ONDCP for reducing the treatment gap are a 20% reduction by FY 2002 and a 50% reduction by FY 2007. The specific performance measures, at are proposed for tracking progress on these goals are:

1) Reduction in the treatment gap
2) Reduction in waiting time for treatment, and
3) Improved client outcomes.

Only by engaging in a balanced set of programs focused on each of these targets will it be possible to achieve the goals set forth in the National Drug Control Strategy. CSAT programs also support the Department's disease prevention and health promotion activities including Healthy People 2010, *Women's Health* and *Reducing Racial Disparities in Health Status*. These activities constitute the heart of SAMHSA's 2001 request based on a strategy to improve the accountability of and access to appropriate treatment services that deliver quality care. The following discussion presents specific CSAT activities and the respective Drug Strategy targets that they are intended to affect.

<u>Reduction in the Treatment Gap Through Increased Availability of Treatment</u>

At the center of this Nation's substance abuse problem is the lack of a comprehensive national system for treating of alcoholics and illicit drug users. Making effective treatment more available is key to correcting this problem.

Approximately 14 million people are current users of illicit drugs, with 2.58 million users between the ages of 12-17 and 4.06 million between the ages of 18-25. Data indicate that 5.7 million Americans who are abusing or are dependent on drugs are severely in need of addiction treatment. ONDCP reports that existing t1reatment capacity is sufficient for only about 20% of adolescents in immediate need of treatment and that there are an estimated 4 million chronic drug users. They also state that the National Association of Drug Court Professionals has reported one of the main obstacles to increasing the number of drug courts is that the need for increased treatment resources is becoming more acute. Of these individuals, only 2.1

million can be served through the existing publicly funded treatment system, leaving a gap of 3.6 million people severely needing substance abuse treatment. According to SAMHSA estimates, closing the treatment gap would require spending up to $8 billion at the Federal level.

When the treatment needs of problem drinkers are also taken into consideration, the treatment gap only widens. Of the estimated 111 million Americans who drink alcohol, approximately 32 million report one or more alcohol-related problems. Approximately 4.6 million adolescents between the ages of 12-17 are current users of alcohol; these underage individuals, by definition, are problem drinkers.

Two programs integral to reducing the treatment gap are the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Targeted Capacity Expansion (TCE) Program. Groundwork for the TCE effort was completed in 1998, and significant increases were received in 1999 for both TCE and SAPT Block Grant programs. The FY 2001 request includes increases for both programs.

The TCE program is specifically designed to address gaps in local treatment capacity by supporting rapid and strategic responses to the demand for alcohol and drug abuse treatment services and through targeting vulnerable, hard-to-reach populations. States target SAPT Block Grant funds to service needs by incorporating data on new and emerging problems in their planning and allocation strategies, but insufficient funding and previous resource commitments often adversely affect their
capability to rapidly address newly identified service needs. The goal of the TCE program is to provide local communities the opportunity to create or expand service capacity through an integrated, creative, timely, and community-based response to a targeted, well-documented substance abuse treatment capacity problem. Treatment services supported under TCE must be based on sound, scientifically-based theory or empirical evidence of effectiveness.

In an effort to target funding at local communities facing these and many other treatment issues, in FY 2001 CSAT proposes to create comprehensive systems of care in smaller towns, rural areas, and mid-size cities. This expansion of targeted programs, called strengthening communities, will focus on encouraging the development of creative and comprehensive drug and alcohol early intervention and treatment systems for adults, but it will also have an important adolescent component. Other populations targeted by Strengthening Communities include women, homeless, co-morbid, rural, and poly-substance abusers.

The health care system for adolescents is fragmented, insufficiently informed about specific adolescent problems, and ill equipped to effectively address many of the problems with which teens present, especially given that many teens present with poly-drug use needs (e.g., alcohol and marijuana and heroin). Youth do not do well in treatment programs designed for adults; rather, they need programs designed to meet their specific needs. For example, traditional 12-step addiction recovery programs usually are, adjusted for teens to focus on the first five steps, which are more developmentally appropriate for adolescents. Residential treatment programs need to be less confrontational for teens than adults and some teens may need treatment longer than the standard 28 days (Treatment Improvement Protocol #31 - *Screening and Assessing Adolescents for Substance Use Disorders*, 1999).

Building upon program expansion to be accomplished in FY 2000, CSAT will also fund additional grants in the TCE-HIV/AIDS initiative. These efforts, which began with funding provided by the Congressional Black Caucus in FY 1999, focus on enhancement and expansion of substance abuse treatment services related to HIV/AIDS in African-American, Hispanic, and other racial/ethnic minority communities affected by the twin epidemics of substance abuse and HIV/AIDS.

The SAPT Block Grant remains the primary tool the Federal government uses to support and expand substance abuse prevention and treatment services. Federal funding for public treatment facilities, as a percentage of all funding being used at the State level for substance abuse treatment, ranges from a low of 11% in one State to a high of 84% in another. Increased funding is necessary to accommodate higher service costs as well as to provide for additional service capacity. The proposed $1.631 billion funding level for the SAPT Block Grant, together with other CSAT treatment program funding increases requested for FY 2001, would provide treatment for approximately 414,000. Due to the leveraging effect the Block Grant has on State and local governments, total treatment capacity through publicly-funded programs in FY 2001 will serve an estimated 900,000 persons.

Reduction in Waiting Time Through Improved Access to Treatment

In addition to the obvious need for additional treatment capacity, reducing barriers to treatment and improving access are essential components to achieving the target of reducing the waiting time for treatment. Access to treatment services is a significant issue which cuts across numerous populations. Even with significant advances in the art, science and technology of substance abuse treatment, little improvement will occur in the overall health of the population if they cannot access the care they need.

Often, the waiting time to enter treatment deters substance abusers from actually entering. There are extensive waiting lists for treatment and ancillary services in many States. People who are not easy to contact, such as homeless people, are often dropped from the lists. There are many other barriers to treatment including inadequate financial resources; lack of timely treatment; lack of child care, outreach and other related services; lack of easy physical access; and a variety of other barriers. The *Strengthening Communities* initiative will encourage the development of creative, comprehensive and accessible drug and alcohol treatment systems in locations with continuing major drug problems. CSAT plans to continue its work on parity for substance abuse treatment services as well as on the need for gender, culturally and linguistically appropriate services. Continuation of the Recovery Community Support Program will assist in providing the recovery community with a public voice to communicate its unique perspectives and insights regarding the formal delivery systems, as well as heighten public awareness and deal with anti-stigma issues.

Improved Effectiveness, Quality and Outcomes of Treatment

Central to treatment success is the adoption of best practices within the service system. Recently acquired knowledge provides the impetus for a greater focus on knowledge application activities in FY 2001. These activities will include product development and dissemination activities as well as technology transfer and training.

The FY 2001 request proposes continuation of the Practice/Research Collaboratives program, designed to bring researchers, providers, and other community leaders together to review available data on substance abuse treatment, develop plans to improve services, and conduct studies needed to assure that improvements are made. Another component of this effort is the expansion and broadening of an existing network of curriculum developers, trainers and consultants that is regionally based and sensitive to particular needs of that region.

CSAT, together with its State partners and the treatment community, is actively engaged in the development of performance and outcome measurement instruments and monitoring systems. The goal of these technologies is to make the provider community more accountable by having more effective, data-based monitoring of treatment activities.

CSAT is also assuming responsibility for oversight and monitoring of treatment quality in the nation's opioid addiction treatment system. This involves Federally approved programs and individual practitioners that use anti-addiction medications such as methadone, levo-acetyl-alpha-methadol (LAAM) and newer medications currently under research (e.g., buprenorphine). More focus will be directed to the need for treatment providers to upgrade the quality of services and pay more attention to the outcomes of care.

Substance abuse affects a wide range of other social service systems (e.g., health, mental health, criminal justice, welfare, labor, etc.). Agencies across the Department of Health and Human Services, and across all of the Federal Government, as well as States, local communities and providers, must work in concert to reduce substance use and abuse. In FY 2001, CSAT plans to continue partnering efforts with: NIAAA, in evaluating adolescent alcohol treatment strategies and preventing DUI recidivism; CDC, in looking at substance abuse and HIV; NIDA, in collaborating on effective treatment approaches; and, the Department of Justice, in assuring current technical assistance for substance abuse treatment in the justice system. In addition to these types of ongoing activities, CSAT plans to form new partnerships looking at welfare and job training, expanding family drug courts, providing substance abuse treatment services for the cognitively and physically disabled, and other opportunities for collaboration as they arise.

The substance abuse treatment system is a mixture of treatment modalities, clients and treatment needs. CSAT believes that only by engaging in a balanced set of activities that is targeted toward each of the areas discussed above, will it be possible to achieve the goals set in the National Drug Control Strategy of reducing the number of substance abusers and the health and social costs of drug use.

KDA PROGRAM ACCOMPLISHMENT

Program/Initiative: RWC/PPW CROSS-SITE EVALUATION

In FY 1996, CSAT initiated a cross-site evaluation of 24 Pregnant and Postpartum Women (PPW) Demonstration Programs grantees and 26 Residential Women and Children (RWC) grantees. The evaluation focused on the effectiveness of the programs in reducing substance abuse and illegal activities among the women; factors that contribute to retention in residential treatment, successful completion of treatment, and treatment outcomes; and, improvement in the overall health and welfare of children who participate in residential treatment with their mothers. All findings to date are preliminary, but some strong trends appear in preliminary analyses.

Goal 1: Treatment Retention and Length of Stay

Retention in treatment and completion of treatment are goals of RWC/PPW programs, since many studies find that a longer length of stay and treatment completion are linked to better treatment outcomes.

Findings:

- The average client length of stay in the programs was 151 days (about 5 months).

- Women who brought infants or young children with them into RWC/PPW treatment had higher program completion rates and longer average length of stay than women who did not bring any of their children into treatment.

Goal 2: Infant Morbidity and Mortality

Findings:

- Preliminary findings strongly support the value of residential substance abuse treatment for pregnant women in reducing adverse birth outcome. The percentage of low birth weight births among PPW pregnancies (5.7%) was far lower than the average rate for drug-exposed infants (30%), based on prior studies of prenatal drug use, and lower than the national rate of 7.5 % for the general population.

- The beneficial effects of treatment in reducing rates of pre-term and low birth weight deliveries were especially pronounced among African-American women. Rates of adverse outcomes of in-treatment pregnancies were not just lower than would be expected for substance abusing women, but considerably lower than are seen in the general population. Compared to rates of low birth weight delivery of 30 % among all substance abusing women and of 13 % among African-American women in the general population, the rate of low birth weight deliveries among African-American PPW clients was 6.7 %.

- Prior to entering treatment, the percentage of reported infant deaths among PPW clients was 1.5 %, twice the national average (0.7%). The PPW/RWC program infant mortality rate of 0.3 %, is far below the expected rate for substance-abusing women and lower than the national average.

PREGNANCY OUTCOME FINDINGS FOR PPW CLIENTS[1]			
		PPW CLIENTS	
MORTALITY/MORBIDITY INDICATOR	ALL U.S. WOMEN 1997[2]	PRIOR PREGNANCIES (N=4,218 LBs)	TREATMENT PREGNANCIES (N=592 LBs)
MORTALITY			
Fetal mortality rate (per 100 LBs and FDs)	0.7[3]	7.7	1.5
Infant mortality rate (per 100 LBs)	0.7[4]	1.5	0.3
MORBIDITY			
Low birth weight rate (per 100 LBs)	7.5[5]	6.8	5.7
Pre-term delivery rate (per 100 LBs)	11.4[6]	6.9	7.3
NICU rate (per 100 LBs)[7]	-	5.5	10.6
AOD-positive rate (per 100 LBs)[8]	-	10.7	9.1

1 LB = live birth; FD = fetal death (miscarriage or stillbirth).

2 Source: MacDorman, M. & Atkinson, J. Infant mortality statistics from the 1997 period linked birth/infant death data set. National Vital Statistics Report; vol 47 no. 23. Hyattsville, MD: National Center for Health Statistics).

3 Number of fetal deaths of 20 weeks or more gestation per 100 live births plus fetal deaths.

4 Number of infant deaths (under one year of age) per 100 live births.

5 Less than 2,500 grams (5 lbs., 8 oz.).

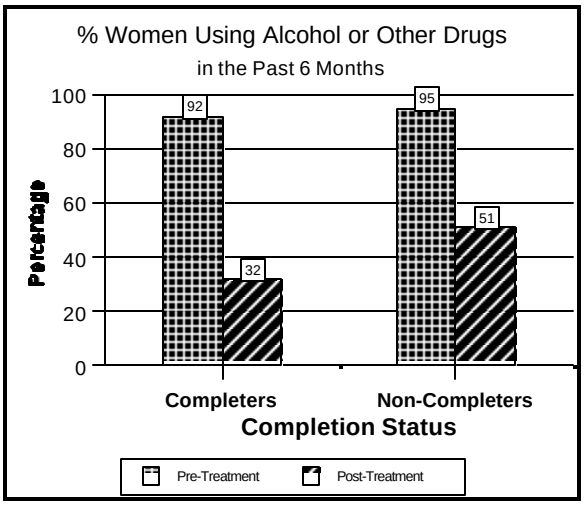
6 Births of less than 37 completed weeks of gestation.

7 Number of infants who received treatment in a hospital Neonatal Intensive Care Unit per 100 live births.

8 Number of infants who tested positive for alcohol or drugs per 100 live births.

Goal 3: Changes in Women's Behavior

Reducing drug use and involvement in criminal behaviors are two major objectives of the RWC/PPW programs. Client behaviors were compared during the 6 months following treatment to their pre-treatment behaviors.



Findings (preliminary):

- Women in RWC/PPW programs demonstrated significant reductions in the use of drugs and alcohol after treatment, with treatment completers demonstrating greater reductions in substance use compared to non-completers.

- Both RWC/PPW treatment completers and non-completers reported far less involvement in illegal activities after treatment, with completers demonstrated a greater reduction in illegal activities than non-completers. Among completers, 52 % reported involvement in illegal activities in the 30 days prior to admission while 13 % reported involvement in illegal activities in the 30 days prior to their post-treatment interviews. Among non-completers, 45 % reported involvement in illegal activities in the 30 days prior to admission versus 20 % in the 30 days prior to their follow-up interviews.

Goal 4: Family Preservation

Many clients were at high risk for losing custody of their children, or had already lost custody of their children at the time of treatment entry. Another objective of these programs was to see if RWC/PPW treatment participation might influence preservation of the family.

Findings (preliminary):

- Treatment participation and completion were positively related to the retention of child custody; 95 % of children who entered treatment with their mothers remained in their mothers' care at treatment exit if their mothers completed treatment.

- Approximately 75 % of children who were in foster care just prior to admission were discharged to their mothers' custody at treatment exit.

Application:

The results of the RWC/PPW cross-site evaluation are preliminary. When final results are available, they will be disseminated widely to treatment providers to put into practice.

KDA PROGRAM ACCOMPLISHMENT

Program/Initiative: MARIJUANA TREATMENT PROJECT (MTP)

The MTP (Marijuana Treatment Project), is a three-year, randomized clinical trial investigating the effectiveness of brief interventions for individuals who are dependent on cannabis. The project compared two focused treatments for dependent individuals from differing socio-economic and racial backgrounds.

Goal: Determine Effectiveness of Brief Interventions

! The MTP project sought answers to two primary questions:

--Are focused interventions any more effective than no treatment for marijuana problems?

-- Does a nine-session treatment produce better outcomes than a two-session treatment?

Findings:

- As few as two treatment sessions (brief treatment) for marijuana use produces a significant reduction in smoking behavior.
- Nine sessions (extended) produces a significant proportion of abstinence and reduction as well.
- Both the brief and extended treatment sessions are more effective than no treatment.

Application:

Cannabis dependence is the most common form of dependence associated with illicit drugs. Recent surveys of publicly funded drug treatment programs, Drug Abuse Treatment Outcome Study (DATOS) and National Treatment Improvement Evaluation Study (NTIES), found that a large percentage of admissions reported the primary drug problem for which they sought treatment was marijuana use or marijuana in combination with alcohol. Despite the large number of people seeking treatment for cannabis dependence, there has been no consensus within the scientific or clinical community about the type or intensity of treatment that is optimally effective. The MTP results are being communicated to the treatment providers nationwide.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Center for Substance Abuse Treatment

Mechanism Table

(Dollars in thousands)

	FY 1999 Actual		FY 2000 Pre-Rescission Appropriation		FY 2000 Final Appropriation		FY 2001 Estimate	
Knowledge Development and Application:	**No.**	**Amt.**	**No.**	**Amt.**	**No.**	**Amt.**	**No.**	**Amt.**
Grants/Cooperative Agreements:								
Continuations	131	$56,043	150	$44,675	150	$44,675	117	$55,662
Competing:								
New	65	18,806	31	14,000	31	14,000	30	4,500
Supplements:								
Administrative	---	---	---	---	---	---	---	---
Competing	---	---	7	1,000	7	1,000	14	7,600
Total, Grants/Cooperative Agreements	196	74,849	188	59,675	188	59,675	161	67,762
Contracts	126	39,165	125	39,534	125	39,534	67	26,947
Technical Assistance	16	236	15	250	15	250	15	250
Review Costs	10	797	10	800	10	800	4	300
Total KDA	**348**	**115,047**	**338**	**100,259**	**338**	**100,259**	**247**	**95,259**
Targeted Capacity Expansion:								
Grants:								
Continuations	41	24,445	112	55,381	112	55,381	171	85,352
Competing:								
New	65	28,880	100	54,416	100	54,416	103	48,819
Renewal	---	---	---	---	---	---	41	24,445
Total, Grants	106	53,325	212	109,797	212	109,797	315	158,616
Contracts	1	1,971	5	4,465	5	4,465	5	4,500
Technical Assistance	---	---	---	---	---	---	---	---
Review Costs	7	43	7	45	7	45	7	45
Total Targeted Capacity Expansion	**114**	**55,339**	**224**	**114,307**	**224**	**114,307**	**327**	**163,161**
Substance Abuse Block Grant:								
Total, Substance Abuse Block Grant	**60**	**1,585,000**	**60**	**1,600,000**	**60**	**1,600,000**	**60**	**1,631,000**
Set-Aside (Non-Add)	---	(79,250)	---	(80,000)	---	(80,000)	---	(81,550)

D. Center for Substance Abuse Treatment
1. Knowledge Development and Application

Authorizing Legislation - New legislation has been submitted.

	1999 Actual	2000 Pre-rescission Appropriation	2000 Final Appropriation	2001 Estimate	Increase or Decrease
BA	$115,297,000	$100,259,000	$100,259,000	$95,259,000	-$5,000,000

2001 Authorization

PHSA Section 501 . . . . . Indefinite

Purpose and Method of Operation

CSAT's Knowledge Development and Application program, begun in 1996, was designed to support development and testing of new and innovative treatment approaches, disseminate information on those systems shown to be most effective, and promote the adoption of best practices. A major focus has been on knowledge development with programs such as: *Marijuana Interventions* for both adults and youth; *Methamphetamine Treatment*; *Homelessness Collaborations*; *Criminal Justice Treatment Networks*; the *Community Action Grant* program; and *Treatment for Adolescent Alcohol Abuse and Alcoholism*. CSAT has continued to provide phase-out funding for the pre-1996 demonstration programs, such as the *Residential Treatment Program for Women and Their Children*, the *Pregnant and Post-Partum Women's Program*, and the *Rural, Remote, and Culturally Distinct* program, so that important evaluations of these programs could be completed.

Another major purpose of CSAT KD&A resources has been in support of a network of regionally-based curriculum developers, trainers, and consultants that is sensitive to the particular cultural and treatment needs of the people in that region *(the Addiction Technology Transfer Centers, or ATTC's)*. The types of services available from this network range from traditional training activities through on-site assistance and mentoring. In addition, CSAT's *Practice/Research Collaboratives* program, new in 1999, is designed to bring researchers, providers, and other community leaders together to review available data on substance abuse and substance abuse treatment, to develop plans for improving the services that are available, and to conduct evaluation studies needed to assure that the improvements are made.

KD&A funding supports the various evaluation projects underway at CSAT, including the *Persistent Effects of Treatment Study (PETS), Managed Care Studies*, National Evaluation Data Services (NEDS),; and the review of *National Health Spending*. Data from this family of studies are providing valuable knowledge about "what works" in substance abuse treatment, the relative costs of treatment, and the long-term financial and human benefits of treatment. This knowledge is compared to overall societal

costs of the failure to provide appropriate and effective treatment and rehabilitation of substance abusers, whether through programs funded by Federal, State or local governments, or by the private sector.

Funding for the Knowledge Development and Application program during the last five years has been as follows:

	Funding	FTE
1996	$89,777,000	---
1997	155,868,000	---
1998 *	131,136,000	---
1999 *	115,297,000	---
2000 *	100,259,000	---

* Excludes funds transferred to the Targeted Capacity Expansion budget line.

Rationale for the Budget Request

The budget proposes a reduction of $5 million for this activity for 2001. CSAT will have sufficient available funding to support the continuation of all Knowledge Development and Application projects.

The KDA program will support actions required to transfer the Department of Health and Human Services' oversight of methadone/LAAM treatment programs from the Food and Drug Administration (FDA) to SAMHSA/CSAT *(Opioid Treatment Program Accreditation*). Institute of Medicine (IOM) and National Institutes of Health (NIH) consensus panels both recommended that a regulated system of accreditation for America's opioid agonist therapy clinics would be far superior to the current, outdated system of direct federal inspection. This responsibility has been assigned to SAMHSA and CSAT. When accreditation is fully implemented, anticipated outcomes include:

- A SAMHSA/CSAT accreditation program using procedures comparable to those used in the rest of the healthcare system. It is expected that opioid treatment programs/clinics will be modernized and brought into the mainstream of medical care.

- Accreditation surveys by treatment professionals. The accreditation process will promote continuous quality improvement procedures in each treatment clinic surveyed.

- Better treatment outcomes. Even more than the current estimate of 15% of patients should become stable and eligible for less intensive treatment in an office-based opioid therapy (OBOT) setting.

One of the domains identified by the National Treatment Plan was "Reducing Stigma and Changing Attitudes". To further incorporate recommendations from the NTP, CSAT intends to re-announce the Recovery Community Support Program (RCSP) which is designed to increase public understanding about consumers of substance abuse treatment services by collaborating with a grassroots constituency in support of recovery. The NTP recognized that this involves more than government entities; in fact, that the private

sector including community groups, chambers of commerce, faith communities, and private foundations must play a major role. To that end, CSAT will expand the scope of the RCSP initiative and increase stakeholder involvement in an effort to help eliminate the stigma associated with drug addiction and increase the recognition that drug and alcohol addiction are treatable diseases. The estimated amount of funding for this initiative in FY 2001 is $4 million.

Another of the NTP domains for which CSAT has already implemented preliminary recommendations is "Improving and Strengthening Treatment Systems". The Community Action Grant program, begun in FY 1999, provides communities with resources to develop consensus on adoption of a best practice and to implement that practice using providers who wish to work with others in their communities to improve the availability of substance abuse treatment. Estimated funding for this program in FY 2001 is $1 million.

The Addiction Technology Transfer Centers (ATTCs) are planned for continuation in FY 2001 in order to provide training and technical assistance resources to support the implementation of the NTP's recommendations. The NTP further recommends the development of training programs or courses for organizational leaders, focusing on management skills (e.g., hiring and retention issues, allocation of resources, infrastructure development, facilities improvement, etc.). The ATTCs also serve in the training of treatment providers in areas such as cultural competence, assessment and monitoring processes. The estimated amount of funding for this initiative in FY 2001 is $7.5 million.

A third NTP domain for which CSAT has laid the groundwork is "Connecting Research and Services". In FY 1999, the Practice/Research Collaboratives (PRC) program was begun, a program which brings researchers, providers, and other community leaders together to review available data on substance abuse and treatment and develop plans for improving the services that are available. Nine PRC Development grants were awarded in FY 1999. The second phase, Implementation Grants, to be funded in FY 2000, will allow grantees the opportunity to focus on the highest priority needs for both research and knowledge application by actually implementing the plan developed by the network. The estimated amount of funding for this initiative in FY 2001 is $3 million.

The distribution of KDA resources for selected program areas follows:

	1999 Actual	2000 Estimate	2001 Estimate	Difference
Recovery Community Support Program Amount (thousands)	$3,662	$3,662	$4,000	+$338
Number of Recovery Community Support Program Awards	19	19	22	+3
Community Action Grant Amount (thousands)	$1,000	$1,000	$1,000	---

	1999 Actual	2000 Estimate	2001 Estimate	Difference
Number of New Community Action Grant Awards	10	10	10	---
Addiction Technology Transfer Centers Amount (thousands)	$7,792	$7,792	$7,500	-$292
Number of Recovery Community Support Program Awards	14	14	14	---
Practice/Research Collaboratives Amount	$1,750	$3,000	$3,000	---
Practice/Research Collaboratives Awards	9	7	7	—

D. Center for Substance Abuse Treatment
2. Targeted Capacity Expansion

Authorizing Legislation - New legislation has been submitted.

	1999 Actual	2000 Pre-rescission Appropriation	2000 Final Appropriation	2001 Estimate	Increase or Decrease
BA	$55,089,000	$114,307,000	$114,307,000	$163,161,000	+$48,854,000

2001 Authorization

PHSA Section 501 . . . . . Indefinite

Purpose and Method of Operation

Fewer than two million of the more than five million persons who use and abuse alcohol and other drugs can be served through existing publicly-funded treatment systems. Substance abuse patterns vary greatly regionally and locally across the United States, from increased heroin use in the Northeast, to methamphetamine use in the Southwest and Midwest. This fact, coupled with the significant gap between available treatment capacity and current demand, often impedes the existing treatment system's ability to quickly and strategically respond to emerging needs. This program provides local communities the opportunity to create or expand the ability to provide an integrated, creative and community-based response to a targeted, well-documented substance abuse treatment capacity problem.

In FY 1998, CSAT initiated the Targeted Capacity Expansion (TCE) Program to provide for rapid and strategic responses to the demand for substance abuse treatment services that are more local and regional in nature. Examples of this included expansion of specialized services for women in three regions of Colorado, especially the underserved rural areas; expansion of outpatient methadone treatment in the under-represented areas of Chicago; and expansion of medical and non-hospital detoxification services in Philadelphia. Grants were awarded to municipal, County, State and tribal governments to help close the gap in treatment for emerging substance abuse problems. CSAT awarded 65 new grants in FY 1999. Included in this number were 35 grants to address the crisis that exists regarding substance abuse and HIV/AIDS in African American, Hispanic, and other racial and ethnic minority communities. The FY 2000 appropriation provided sufficient funding to continue all 106 grants that were awarded in FY 1998/99, and to make approximately 70 new TCE grant awards and 30 new TCE-HIV/AIDS grant awards.

The expected outcomes of the TCE program are:

C Increased accessibility to treatment;

- Reduced treatment gap;
- Reduced demand for illegal substances;
- Reduced or eliminated waiting time to enter treatment;
- Reduced number of chronic substance abusers.

While there are many sub-populations that are intended to be targeted with these funds, one in particular is youth. A 1991 report from the Office of Technology Assessment quoted estimates that suggested one of every five adolescents has at least one serious health problem. The report also concluded that there are major barriers that adolescents face in gaining access to treatment. Although adolescents who are both poor and members of racial or ethnic minority groups are at particular risk because of a lack of safety nets to help them negotiate these difficult years, the problems are not confined to this population. Issues related to availability, access, income, insurance coverage, legal challenges, and other potential social-psychological barriers are causing adolescent health issues to emerge in all sectors of society. Without a focused, coordinated approach, fostered by the multiple Federal, State, and local agencies that share a portion of the adolescent health treatment and prevention efforts, appropriate health promotion, early intervention, treatment, and necessary environmental support will continue to deteriorate, placing more of our Nation's youth at risk.

Funding for the Targeted Capacity Expansion program during the last five years has been as follows:

	Funding	FTE
1996	---	---
1997	---	---
1998 *	$24,732,000	---
1999 *	55,089,000	---
2000 *	114,307,000	---

* Reflects funding transfer from the Knowledge Development and Application budget line.

Rationale for the Budget Request

In support of ONDCP's goal of reducing the treatment gap, the FY 2001 request includes $163.1 million for the TCE program in 2001, an increase of $48.9 million over the 2000 current estimate. The proposed increase will fund approximately 100 new grants. The budget request would provide treatment for approximately 24,000 more individuals than the 2000 appropriation, a total of over 65,000 persons served by TCE-funded programs.

The design of the FY 2001 TCE program is threefold. First, and historically, the core program is designed to address gaps in treatment capacity at the local level by supporting rapid and strategic responses to demand for alcohol and drug abuse treatment services. The response to treatment capacity problems may include communities with serious, emerging drug problems (e.g., alcohol and marijuana for youth;

methamphetamine in the Midwest; heroin and cocaine in the East), as well as communities with innovative solutions to unmet needs. The core TCE initiative in FY 2001 will focus on vulnerable populations including, but not limited to, youth, women, homeless, co-morbid and rural. The estimated amount of funding for this activity in FY 2001 is $24.4 million.

Second, continuing the agenda set by the Congressional Black Caucus in FY 1999 and continued and expanded in 2000, the HIV/AIDS TCE initiative in African American, Hispanic and other ethnic/racial minority communities will be expanded. The estimated amount of funding for this activity is $15 million.

Third, the request includes an initiative designed to enhance both drug and alcohol treatment availability and accessability in small towns, rural areas, and mid-size cities for both adults and adolescents. This *Strengthening Communities* initiative will focus on encouraging the development of creative and comprehensive drug and alcohol treatment systems in areas with continuing major drug problems. Emphasis will be placed on helping communities help themselves to create: (1) primary care treatment and referral sites which would serve those users for whom brief interventions would be effective (e.g., marijuana and alcohol abusers) and refer those who require more intensive treatment to the speciality treatment system (e.g., heroin and crack cocaine addicts); (2) networks to ease addicts' access to services throughout the city, and transition recovering addicts back to the community; (3) early intervention services to provide low-intensity services to people whose substance-related problems are not yet severe; (4) comprehensive treatment centers designed to house different treatment modes under one roof in order to enhance cooperation between and among providers for better care; (5) detoxification plus treatment programs to detox patients economically and effectively and ensure their immediate entry to treatment; and (6) outreach activities which research has shown to be very effective in facilitating access to treatment. The estimated amount of funding for this activity is $34 million.

Associated with the TCE goal of increasing treatment capacity is the need to increase accessibility and eliminate systemic barriers to treatment. This is the focus of the *Strengthening Communities* initiative. In developing future policies applicable to TCE program, the possibility of including a matching requirement will be considered. Large proportions of alcohol and drug users are found in populations served by a variety of health and human service agencies. Primary care organizations, social service agencies, mental health, welfare, and child welfare agencies, jails and detention centers each contain significant numbers of drug- and/or alcohol-dependent individuals. There is some evidence, in fact, that substance-abusing individuals are more likely to be found or seek help from other than substance abuse treatment specialty service organizations. However, there is also evidence that the organization, financing, entitlement, and authorities of health and human service systems and other public systems have competing requirements that create barriers to access to the needed type and intensity of substance abuse treatment (rehabilitation) services. The FY 2001 proposal would implement inter-organizational models that improve access to substance abuse treatment services from other health, human service, and criminal justice organizations.

These proposals further the goals of the ***National Treatment Plan*** domain of "Closing the Treatment Gap". In order to close the treatment gap, it is necessary to develop a plan that would allow for the effective and appropriate care of all individuals in need of treatment regardless of demographic or other factors that

may impede access to care. From preliminary NTP findings, three areas for attention emerged: resource allocation; quality care and outcome measures; and, inter-system linkages. The core TCE program as well as the HIV/AIDS TCE program have focused on resource allocation (e.g., provision of full continuum of care, increased financial resources, sustained funding for identification, assessment, monitoring, etc.) and quality care and outcome measures (e.g., evidence-based standards for quality care and practices, consensus on critical data elements to measure quality of care and treatment outcomes for clients and providers).

The *Strengthening Communities* initiative continues with the first two areas while also addressing the third which is the issue of inter-system linkages, emphasizing the benefit of multiple systems working together to ensure that appropriate effective care is available to all individuals in need of treatment - a "No Wrong Door" approach. It is this initiative which seeks to create a framework for alcohol and drug treatment, so that regardless of which human service or criminal justice system an individual appears in, that person can be identified, assessed and treated in a clinically appropriate manner. These recommendations, taken together, provide a strategy to address the issues of ensuring that those in need of treatment actually receive it, ensuring that sufficient public and private resources are available, and ensuring that the types and levels of care needed are available. That is the major focus of the TCE program.

In developing future policies applicable to this program, the possibility of including a matching requirement will be considered.

D. Center for Substance Abuse Treatment
3. Substance Abuse Prevention and Treatment Block Grant

Authorizing Legislation - New legislation has been submitted.

	1999 Actual	2000 Pre-rescission Appropriation	2000 Final Appropriation	2001 Estimate	Increase or Decrease
Total . . .	$1,585,000,000	$1,600,000,000	$1,600,000,000	$1,631,000,000	+$31,000,000
(Treatment)	($1,204,600,000)	($1,216,000,000)	($1,216,000,000)	($1,239,560,000)	(+$23,560,000)

2001 Authorization

Substance Abuse Block Grant . . . . . Expired

Purpose and Method of Operation

The purpose of the SAPT Block Grant (SAPTBG) is to support treatment and prevention services for persons at risk of or abusing alcohol and other drugs. It is the cornerstone of States' substance abuse programs, accounting for 40% of public funds expended for treatment and prevention (1995). The SAPT Block Grant is designed to provide States the flexibility to plan, carry out and evaluate substance abuse prevention and treatment services to individuals and families; Federal funding for public treatment facilities, as a percentage of all funding being used at the State-level for substance abuse treatment, ranges from a low of 11% in one State to a high of 84% in another. In 1997, nineteen States reported that they received the majority of their funding for support of substance abuse from the SAPT Block Grant. Over 7,500 community-based organizations receive SAPTBG funding.

The SAPTBG is a formula-driven grant, and it includes numerous mandatory distributions and set-asides as prescribed in current law. Although reauthorization legislation has been introduced, P.L. 102-321 continues to be the legislative authority for distribution and management of the SAPTBG. For FY 2000, the appropriations act provided that "Each State's allotment for fiscal year 2000 for programs under this subpart [*Section 1933(b), Public Health Services Act*] shall be equal to such State's allotment for such programs for fiscal year 1999...." unless the total appropriated for the SAPTBG were less than 1999 appropriation. This one year hold harmless provision has been applied to FY 2000 State allotments.

Data collected from the SAPTBG application do not provide information on services delivered to one very vulnerable population, homeless persons. Recent changes to the SAPTBG application include new voluntary outcome measures for the "living status" of the clients. These data collection efforts will provide a baseline of information related to homeless persons served through CSAT programs and will be available

at the end of calender year 2000. States have, however, exercised their discretion to use SAPTBG funds, as well as State funds, to provide treatment to those who are homeless. Through other reporting mechanisms, States have indicated that homeless persons account for 21.3% of all admissions for substance abuse to publicly funded programs (Treatment Episode Data Set, 1999). The following are examples of programs funded through the SAPTBG that provide for the homeless:

- Pennsylvania -The development of a "Family Life Enrichment" program for homeless recovering persons and their families.

- Michigan - Outreach activity for IDUs at women's shelter and homeless shelters.

- California - Central intake mobile units to provide assessment and referral at two homeless shelters, the main county jail, and one county mental health regional office.

- New York - On-site evaluation/engagement and referral service to men and women living in more than ten New York City Homeless Shelters.

- Minnesota - Five programs for chronic and homeless users that demonstrated a cost-effective system for the care of chronic and homeless users so that community costs are reduced.

- Indiana - Intensive outpatient and intervention services targeted for the homeless men and women.

Expected outcomes from the SAPT Block Grant are as follows:

- Increased accessibility to treatment;
- Reduced treatment gap;
- Reduced demand for illegal substances;
- Reduced or eliminated waiting time to enter treatment;
- Reduced number of chronic substance abusers.

The federal Block Grant set-aside supports activities focusing on the development of outcome measures to assist the States in monitoring and evaluating treatment services funded by the SAPTBG. These activities include the Treatment Outcomes and Performance Pilot Studies (TOPPS I and II) to determine whether or not exportable models of outcome studies could be developed. As with the Targeted Capacity Expansion Program, measures will include the number of people served, outcomes which are still being determined, and customer satisfaction with the technical assistance provided to the States. Recent TOPPS accomplishments are described in the summary following this section.

The development of performance and outcome measures for the Substance Abuse Block Grant through a collaborative partnership has been identified as a critical need. Such an approach requires time to implement and complete, and TOPPS and other related activities are in place to accomplish this goal. States will report

this information in their applications and the reliability and validity will be assessed through project monitoring and periodic compliance reviews.

Funding for the Substance Abuse Prevention and Treatment Block Grant program during the last five years has been as follows:

	Funding	FTE
1996	$1,234,107,000	18
1997 *	1,360,107,000	18
1998 *	1,360,107,000	18
1999	1,585,000,000	18
2000	1,600,000,000	18

* Includes the $50 million SSI supplement provided by P.L.104-121.

Data Elements Used to Calculate State Allotments

FY 2000: The Congressional appropriation language specified that "...each State's allotment for fiscal year 2000 for programs under this subpart shall be equal to such State's allotment for such programs for fiscal year 1999." SAMHSA calculated the FY 2000 allotments such that no state would receive less in FY 2000 than it received in FY 1999. The factors and their data sources used to calculate the allotments in the FY 2000 table are:

- Total Personal Income (TPI) - Bureau of Economic Analysis, Department of Commerce, downloaded from BEA website *http://www.bea.doc.gov/bea/dr/spitbl-d.htm#table2* - Table 2, Personal Income by State and Region, 1993-1997, release date 9/14/98, also available from *http://www.bea.doc.gov/bea/ar1098rem/table1.htm.*

- Resident Population - Bureau of the Census, Department of Commerce, downloaded from Census website, text file AG9797.txt, 1990-to-1997 Annual Time Series of Population Estimates by Age and Sex, By Single Year of Age and Sex, public release date 7/21/98. Census website is *http://www.census.gov/population/estimates/state/stats/ag9797.txt*. (data as of 7/1/97).

- Total Taxable Resources (TTR) - Office of Economic Policy, Department of the Treasury, provided directly to OAS via e-mail, filename NM98EST.wk4, release date 9/30/98, Total Taxable Resources, 1994-1996.

- Population data for the territories based on 1990 Census Data except Micronesia and the Marshall Islands. Population data for Micronesia and the Marshall Islands are based on 1980 census data and the average rate of population change from the 1980 to the 1990 census. Because Micronesia and the Marshall Islands had entered into a Compact of Free Association with the United States,

they were no longer considered territories in 1990 and therefore were not included in the 1990 census.

- A Cost of Services Factor which includes the following: Fair Market Rents for the Section 8 Housing Assistance Payments Program — Fiscal year 1997, from the U.S. Department of Housing and Urban Development, *Federal Register*, September 20, 1996, Vol. 61, No. 184, pages 49576-49635, from website *http://www.hud.gov* and then *ftp@ftp.aspemsys.com*. 1990 Census mean hourly wages for selected industries and occupations (special data file prepared by the Bureau of the Census) updated using the percent change for HCFA mean hourly hospital wages (unadjusted) for FY 1990 (from a special data file prepared by the Health Care Financing Administration) and FY 1993 hourly hospital wages developed from the FY 1997 HCFA Hospital Inpatient Prospective Payment System Wage Rates [published in the *Federal Register*, August 30, 1996, Vol. 61, Number 170, pages 46165-46215 with corrected data published in the *Federal Register* December 19, 1996, Vol. 61, Number 245, pages 66919-66923] in the HCFA public use file "HCFA Hospital Wage Index Survey File" of Hospital Inpatient Prospective Payment System FY 1997 Rates downloaded from website *http://www.hcfa.gov/stats/pufiles.htm* and corrected per the December 1996 revisions.

FY 2001: The factors and their data sources used to calculate the allotments in the FY 2001 table are:

- Total Personal Income (TPI) - Bureau of Economic Analysis, Department of Commerce, downloaded from BEA web site http://www.bea.doc.gov/bea/regional/spi/summary.htm State Personal Income, 1994-1998, release date 7/27/1999.

- Resident Population - Bureau of the Census, Department of Commerce, downloaded from Census website, text file AG9898.txt, Population Estimates for the U.S. and States by Single Year of Age and Sex: July 1, 1998, public release date 6/15/1999. Census web site is http://www.census.gov/population/estimates/state/stats/.

- Total Taxable Resources (TTR) - Office of Economic Policy, Department of the Treasury, provided directly to OAS via e-mail, filename NM99EST.wk4, release date 9/30/1999, Total Taxable Resources, 1995-1997, now also available on the Treasury web site http://www.treas.gov/ttr.

- Population data for the territories based on 1990 Census Data except Micronesia and the Marshall Islands. Population data for Micronesia and the Marshall Islands are based on 1980 census data and the average rate of population change from the 1980 to the 1990 census. Because Micronesia and the Marshall Islands had entered into a Compact of Free Association with the United States, they were no longer considered territories in 1990 and therefore were not included in the 1990 census.

C A Cost of Services Index Factor, updated for this fiscal year under a three-year periodic update, which includes the following:

Fair Market Rents for the Section 8 Housing Assistance Payments Program — Fiscal Year 2000, downloaded from the HUD web site http://www.huduser.org/datasets/fmr: (a) fmr2000f.dbf, dbase file, released 10/1/99, created 9/23/99 (dbase is the only machine-readable format in which the raw data are offered); (b) fmr2000f.txt, text file, FMR data record layout and file description, released 10/1/99, created 9/27/99; (c) 2000f_pre.doc, Word file, Federal Register preamble of the FY2000 FMR calculations, released 10/1/99; and (d) fmrover.wp, WordPerfect version of the Federal Register preamble.

Metropolitan Areas, 1999, released by the Office of Management and Budget 6/30/99, filename MSA99.pdf; used by HUD in development of FMR rates.

Changes in Metropolitan Areas as Defined by the Office of Management and Budget Since June 30, 1999, filename MAUPDATE.txt, released 6/30/99, Bureau of the Census.

1990 Census mean hourly wages for selected industries and occupations (special data file prepared by the Bureau of the Census) updated using the percent change for HCFA mean hourly hospital wages (unadjusted) for FY 1990 (from a special data file prepared by the Health Care Financing Administration) and FY 1996 hourly hospital wages developed from data collected for the establishment of FY 2000 HCFA Hospital Inpatient Prospective Payment System Wage Rates, collected from the HCFA Internet web site http://www.hcfa.gov/stats/pufiles, publically available on August 17, 1999. Both executable and zip versions of the data file WAGEDATA.F96 were available on the web site as 1.2 MB self-extracting files which decompressed to a 5 MB fixed length (i.e. "flat") ASCII file consisting of 5,038 records (one record for each unique facility reporting to HCFA) - the executable version was downloaded and decompressed. Also downloaded was the file for the data record layout (WDF2000), which was available in several formats. Guidance was also provided by HCFA regarding relevant changes which occurred in reporting format between the FY 1997 and FY 2000 hospital wage data releases.

Rationale for the Budget Request

The FY 2001 request includes a $31 million increase for the SAPT Block Grant, for a total program level of $1.631 billion. Because the cost of treatment is subject to inflationary increases year-to-year, the number of persons being provided treatment services with Federal SAPT Block Grant funding in FY 2001 will remain at approximately the same level as in FY 2000.

The National Drug Control Strategy established by ONDCP has set a goal of closing the drug treatment gap by 50% by the year 2007. The Substance Abuse Prevention and Treatment Block Grant will continue as

the dominant funding vehicle for commitment of resources in the continuing attack on the nationwide substance abuse problems. Block Grant increases are necessary to sustain progress in reducing the number of substance abusers in this country. Likewise, the commitment of Block Grant funding toward critical prevention initiatives, particularly those focused on the nation's youth, must also remain strong if growth in the number of new users of substances of abuse is to be curtailed.

The Office of National Drug Control Policy (ONDCP) has charged SAMHSA with the primary responsibility to implement a National Treatment Outcomes Monitoring System (NTOMS) by the year 2002. The purpose of NTOMS is to collect data on an ongoing basis and provide drug treatment providers nationwide with a source of information needed to identify changes in drug abuse treatment outcomes and to identify program-level determinants of change. Outcomes monitoring focuses on assessment of participants' functioning before, during, and following a specific treatment episode, and will be used by policy makers and funding entities, such as Federal and State government agencies and insurers, to hold treatment programs accountable.

CSAT and the Office of Applied Studies (OAS) will collaborate on NTOMS development and implementation, and this effort will also involve coordination with a number of other Departments, including the Department of Veterans Affairs and the Department of Justice. The first-year (2001) costs of NTOMS are estimated at $5 million, to be funded from the SAPT Block Grant set-aside. Set-aside funding will be available for NTOMS since SAMHSA will receive $12 million additional from the Secretary's 1% evaluation resources to partially fund the National Household Survey on Drug Abuse (NHSDA).

PROGRAM ACCOMPLISHMENT

Program/Initiative: TREATMENT OUTCOMES AND PERFORMANCE PILOT STUDIES (TOPPS I)

Goal:

To conduct a series of pilot studies designed to analyze specific components of selected State substance abuse treatment delivery systems in terms of performance and outcome, defining appropriate measures and incorporating them into current State data bases. This initiative was designed to enable the States to improve State system capability, standardization, and accountability. Four States addressed outcomes measures for pregnant women and women with dependent children population; two States addressed outcomes measures for cultural diversity; one State addressed outcome measures for parents/guardians of adolescents in substance abuse treatment.

Findings:

Maryland

The study goal was to develop methodologies for using an existing State client database to determine which publicly-funded adult outpatient treatment programs are most effective, while controlling for differing characteristics of the client populations.

Preliminary Results -

- 40.5% of clients successfully completed treatment
- 70.6% of clients were employed at discharge
- 39.3% of clients reduced their frequency of substance use during treatment
- 73.5% of clients were reported to be using no substances at discharge

Minnesota

The goal was to study the role of parents/guardians in adolescent treatment, and the relationship between their involvement and adolescent treatment outcome.

Preliminary Results -

- The likelihood of abstinence in the 3 months following treatment was almost two times as high (1.8) for adolescents whose parents participated in aftercare than for adolescents whose parents did not participate in aftercare

- Comparing pre-treatment to 3-months post-treatment, the percentage of adolescents saying they experience "a fair amount" or "a lot" of family conflict was significantly reduced from 63.0% to 38.6%.

- In the 3 months following treatment, 35.3% of the adolescents were abstinent from all substances, 46.5% had a 1-2 month stretch of abstinence, and 18.2% had less than one month of continuous abstinence.

- Use of marijuana was reduced by 58.6% when comparing the proportion of adolescents using marijuana in the thirty days prior to treatment to the proportion using marijuana in the thirty days prior to the 3 month post-treatment interview. The mean number of days using marijuana is reduced by 74.5% (comparing the 30 days prior to treatment to the 30 days prior to the 3 month post-treatment interview).

- Involvement in illegal activities was reduced by 34.7% when comparing the proportion of adolescents involved in illegal activities in the thirty days prior to treatment to the proportion involved in illegal activities in the thirty days prior to the 3 month post-treatment interview.

- The likelihood of binge drinking was reduced by 62.9% comparing pre-treatment binge drinking and post-treatment binge drinking.

- Nearly three-quarters (72.7%) of parent/guardians said that they believed treatment was helpful to their child "a fair amount" or "a great deal". Nearly three-quarters (72.6%) of parent/guardians said that they believed treatment was helpful to themselves "a fair amount" or "a great deal".

Oklahoma

The goal was to use administrative data to obtain performance measurement of publicly-funded substance abuse treatment.

Preliminary Results -

- Among the DUI convictions, 1,699 (22.4%) of the FY 1994 cohort had a DUI conviction in the 18 months prior to treatment. Of those, 1,045 (62%) did not have a DUI conviction in the 18 months following treatment.

- A total of 469 clients linked with the Department of Correction Offense File in FY 1994 were found to have received treatment while incarcerated. Among those clients, 15% returned to prison during the two years following release compared to the 20% state rate of second year recidivism after release

- A total of 462 clients in FY 1995 were found in the tax databases for each of the two years before and after their treatment episodes. Sixty-two percent of the clients in the two year study were found to have positive gains in income.

Substance Abuse and Mental Health Services Administration

Substance Abuse Prevention and Treatment Block Grant, FY 1999 - 2001

State / Territory	FY 1999 Actual	FY 2000 Prerescission Appropriation	FY 2000 Final Appropriation	FY 2001 Estimate	Increase/ Decrease
Alabama	$21,666,850	$22,197,312	$22,197,312	$23,130,113	$932,801
Alaska	3,440,623	3,440,623	3,440,623	3,272,688	(167,935)
Arizona	27,127,147	27,127,147	27,127,147	27,481,356	354,209
Arkansas	11,280,281	11,335,103	11,335,103	12,100,889	765,786
California	216,995,385	223,282,608	223,282,608	236,544,535	13,261,927
Colorado	20,297,398	20,297,398	20,297,398	21,508,558	1,211,160
Connecticut	16,405,660	16,405,660	16,405,660	15,837,411	(568,249)
Delaware	5,553,544	5,553,544	5,553,544	3,600,915	(1,952,629)
District Of Columbia	4,952,603	4,952,603	4,952,603	3,153,850	(1,798,753)
Florida	80,256,078	81,263,908	81,263,908	87,180,290	5,916,382
Georgia	40,710,806	41,396,779	41,396,779	45,056,623	3,659,844
Hawaii	6,810,019	6,983,864	6,983,864	6,991,841	7,977
Idaho	5,943,750	5,943,750	5,943,750	6,366,555	422,805
Illinois	61,138,459	61,204,360	61,204,360	65,580,101	4,375,741
Indiana	32,509,147	32,509,147	32,509,147	30,949,619	(1,559,528)
Iowa	12,542,219	12,542,219	12,542,219	12,443,420	(98,799)
Kansas	10,996,215	11,060,004	11,060,004	11,768,766	708,762
Kentucky	19,105,313	19,276,066	19,276,066	19,958,090	682,024
Louisiana	24,828,318	24,828,318	24,828,318	25,246,379	418,061
Maine	5,943,750	5,943,750	5,943,750	5,429,083	(514,667)
Maryland	29,389,161	29,389,161	29,389,161	31,262,343	1,873,182
Massachusetts	33,214,336	33,214,336	33,214,336	30,586,414	(2,627,922)
Michigan	56,510,128	56,510,128	56,510,128	51,310,085	(5,200,043)
Minnesota	20,877,637	20,877,637	20,877,637	21,226,211	348,574
Red Lake Indians	514,557	514,557	514,557	523,148	8,591
Mississippi	13,142,417	13,183,451	13,183,451	13,690,509	507,058
Missouri	24,121,029	24,223,136	24,223,136	25,305,461	1,082,325
Montana	5,584,314	5,584,314	5,584,314	4,318,391	(1,265,923)
Nebraska	7,472,914	7,472,914	7,472,914	7,734,782	261,868
Nevada	9,441,768	9,619,717	9,619,717	10,830,939	1,211,222
New Hampshire	5,943,750	5,943,750	5,943,750	4,185,818	(1,757,932)
New Jersey	45,115,909	45,115,909	45,115,909	46,211,746	1,095,837
New Mexico	8,261,541	8,261,541	8,261,541	8,380,204	118,663
New York	104,711,026	104,711,026	104,711,026	109,137,383	4,426,357
North Carolina	33,404,937	33,680,936	33,680,936	34,675,689	994,753
North Dakota	3,817,151	3,817,151	3,817,151	3,258,974	(558,177)
Ohio	65,062,211	65,062,211	65,062,211	56,761,044	(8,301,167)
Oklahoma	16,185,602	16,559,798	16,559,798	17,358,753	798,955
Oregon	15,114,749	15,268,109	15,268,109	15,568,706	300,597
Pennsylvania	57,670,348	57,670,348	57,670,348	56,887,555	(782,793)

Substance Abuse and Mental Health Services Administration

Substance Abuse Prevention and Treatment Block Grant, FY 1999-2001

State / Territory	FY 1999 Actual	FY 2000 Prerescission Appropriation	FY 2000 Final Appropriation	FY 2001 Estimate	Increase/ Decrease
Rhode Island	5,943,750	5,943,750	5,943,750	5,355,998	(587,752)
South Carolina	18,527,032	18,663,663	18,663,663	19,786,552	1,122,889
South Dakota	3,529,799	3,529,799	3,529,799	3,065,201	(464,598)
Tennessee	25,624,806	25,999,363	25,999,363	28,466,011	2,466,648
Texas	122,543,553	124,118,032	124,118,032	128,039,240	3,921,208
Utah	13,729,782	14,551,928	14,551,928	15,884,143	1,332,215
Vermont	3,774,105	3,774,105	3,774,105	2,510,841	(1,263,264)
Virginia	39,245,298	39,245,298	39,245,298	41,170,203	1,924,905
Washington	30,769,108	31,732,096	31,732,096	33,949,066	2,216,970
West Virginia	8,434,819	8,434,819	8,434,819	8,474,804	39,985
Wisconsin	24,530,479	24,530,479	24,530,479	24,984,238	453,759
Wyoming	2,452,377	2,452,377	2,452,377	1,706,716	(745,661)
State Sub-total	**1,483,163,956**	**1,497,200,000**	**1,497,200,000**	**1,526,208,250**	**29,008,250**
American Samoa	263,259	265,751	265,751	270,900	5,149
Guam	749,439	756,531	756,531	771,189	14,658
Northern Marianas	243,965	246,274	246,274	251,045	4,771
Puerto Rico	19,823,590	20,011,195	20,011,195	20,398,911	387,716
Palau	85,113	85,919	85,919	87,584	1,665
Marshall Islands	251,788	254,171	254,171	259,096	4,925
Micronesia	596,069	601,710	601,710	613,368	11,658
Virgin Islands	573,026	578,449	578,449	589,657	11,208
Territory Sub-total	**22,586,250**	**22,800,000**	**22,800,000**	**23,241,750**	**441,750**
SAMHSA Set-Aside	**79,249,794**	**80,000,000**	**80,000,000**	**81,550,000**	**1,550,000**
GRAND TOTAL	**$1,585,000,000**	**$1,600,000,000**	**$1,600,000,000**	**$1,631,000,000**	**$31,000,000**

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E. SUBSTANCE ABUSE BLOCK GRANT (SET-ASIDE)

Authorizing Legislation - New legislation has been submitted.

	1999 Actual	2000 Appropriation	2001 Estimate	Increase or Decrease
BA (non-add)	($79,250,000)	($80,000,0000)	($81,550,000)	(+$1,550,000)

2001 Authorization

Section 1935 (a), PHS Act . . . . . Expired

Purpose and Method of Operation

The 5% set-aside of the Substance Abuse Prevention and Treatment Block Grant (SAPT) supports data collection, technical assistance, and program evaluation activities throughout the Agency. SAMHSA is the major source of information in the United States on the extent and nature of substance abuse, the supply and cost of services for treating substance abuse, and the number and characteristics of persons in treatment. Much of this information is produced by data systems developed and managed by the Office of Applied Studies (OAS), the Center for Substance Abuse Prevention (CSAP), and the Center for Substance Abuse Treatment (CSAT). They are used by the Department of Health and Human Services, the Office of National Drug Control Policy, the Drug Enforcement Agency, and State and local agencies to plan and evaluate programs to address health and social problems.

Rationale for the Budget Request

A total of $81.6 million will support the continuation of all activities under the 5% Block Grant set-aside. This amount represents an increase of $1.5 million over the FY 2000 appropriation. All current surveys and studies will be maintained and some improved, as described above.

Appropriations language has been added to transfer to SAMHSA $12.0 million from evaluation resources available to the Department under the authority of Section 241 of the Public Health Service Act. These resources, which are not reflected in the SAMHSA budget request, will be used to provide partial support for the expanded Household Survey on Drug Abuse described below, as well as for the National Treatment Outcome Monitoring System described in the CSAT section of the Justification document.

Office Applied Studies (OAS)

The authorizing legislation of SAMHSA requires the annual collection of data on the national incidence and prevalence of substance abuse, emergency room admissions due to a substance abuse problem, and the characteristics and costs of treatment facilities and the number and characteristics of individuals in treatment.

These data are obtained in three major surveys: (1) the National Household Survey on Drug Abuse (NHSDA); (2) the Drug Abuse Warning System (DAWN); and (3) the Drug and Alcohol Services Information System (DASIS). These surveys are the only source of national data on the extent of substance abuse in the general population and the nature of the treatment system. They also provide information critical to evaluating the success of Federal and State substance abuse programs.

National Household Survey on Drug Abuse. Since it began in 1971 the NHSDA has been the primary source of information on the prevalence and incidence of substance abuse in the general, non-institutionalized population. Information provided by the NHSDA is used to study trends in the use of licit and illicit drugs, changing attitudes about substance use, the demand for treatment programs, and factors associated with the initiation of substance use and abuse.

Beginning with the 1999 NHSDA, the sample was expanded from 18,000 to 70,000 respondents. This new sample makes it possible to estimate substance use in the individual States. Based on separate samples of roughly 3900 respondents, substance use can be estimated directly for the eight largest States, which together account for more than 50% of the population. Estimates for each of the other 42 States and the District of Columbia are based on a model that takes into account information obtained from 900 respondents in each State. Given the nature of the sample and the fact that survey questionnaires and methods are identical in every State, we can for the first time compare States with respect to prevalence rates and trends. These State estimates provide information that could be used to direct Federal funds to areas with severe or unique problems.

There are other benefits associated with the increase in the NHSDA sample. The survey now includes 25,000 youth between 12 and 17 years of age, a sample that improves the precision of the estimates for this age group. Because of sample design and size, the NHSDA may now be the best source of information for this age group on substance use and attitudes. The sample contains large number of respondents over the age of 55 years making possible some studies of substance abuse in a population that has not received sufficient attention. The sample also allows for separate, national estimates for minority groups, such as Chinese or Japanese Americans, that could not be captured with a smaller sample,

There are other important changes in the survey, as well. The special module for measuring the use of tobacco products introduced in 1999 has been retained and will provide very precise estimates of trends in use by youth over time. The 2000 NHSDA is collecting information on mental illness in children to better understand the extent and nature of the co-occurrence of mental and substance abuse problems.

In FY 2001 NHSDA questions will be added to determine the extent of serious mental illness in adults and the relationship of this problem with substance abuse. Information on the use, cost, and source of payment for mental health services for both youth and adults is being collected beginning in 2000. Finally, the NHSDA is now being conducted using a computer; answers to the most sensitive questions are entered directly into the computer by respondents. Studies of this technology indicate respondents believe it increases privacy and encourages them to be more truthful in giving answers.

Drug Abuse Warning Network. DAWN collects information on admissions to emergency departments of hospitals or cases seen by medical examiners that are caused by or associated with the use of illicit or licit drugs. The information in DAWN is drawn from medical records. DAWN was developed in the early 1970s by the Drug Enforcement Administration (DEA). Although SAMHSA now supports and manages DAWN and uses DAWN data to track changes in drug abuse problems, the data are still used by DEA for surveillance and resource allocation. They are also used by the Food and Drug Administration (FDA) to identify problems with licit drugs that can not be detected with the limited samples employed in clinical trials.

The Office of Applied Studies is conducting a series of studies to determine the most effective sampling and data collection strategy for DAWN. These studies are prompted by the changes in the health care system which may also affect the use of emergency departments in hospitals, by the need for more extensive information on drug related admissions, and by the demand for more timely information. The studies have prompted the development of a new drug dictionary and experimentation with new communication technologies. The Agency expects to have the changes in place to accelerate the delivery and analysis of DAWN information by 2002.

Drug and Alcohol Services Information System. The DASIS is the only source of national data on the services available for substance abuse treatment and the characteristics of individuals admitted for treatment. DASIS consists of three data sets: (1) the National Facility Register (NFR), which lists all facilities in the country which are recognized by States; (2) the Uniform Facility Data Set (UFDS), which contains information on the services, and resources of treatment facilities in the country including those not recognized by States; and (3) the Treatment Episode Data Set (TEDS), which contains information on every patient admitted to a facility receiving public funds. These data sets are assembled and maintained with support from various State agencies.

Information in the National Facility Register (NFR) provides the basis for a new Treatment Facility Locator System now available to the public on the Web. The information in this new system is up-dated monthly. The Locator permits individuals seeking substance abuse treatment to find a facility in their area providing the type of treatment and services they seek. Street maps indicate the exact location of the facility and travel routes; accompanying text describes the services available and other information, such as type of payment accepted.

Using data now available from TEDS, it is possible to graphically present variations among States with respect to drugs being abused and the characteristics of those being admitted for treatment. For example, TEDS data reveal that recent increases in admissions to facilities are principally the result of an increase in admissions of those 12-17 years. Such analyses have added a new dimension to our ability to track substance abuse problems, the appearance of new drugs, and changing patterns of use.

In addition, OAS conducts studies evaluating the effectiveness of substance abuse treatment and the validity of the information obtained from providers. The largest of these studies, the Alcohol and Drug Services Survey (ADSS), is directed by a team of investigators at Brandeis University. Among other things, ADSS was designed to describe the changes occurring in the organization and structure of the substance abuse

treatment system, and to assess the impact of these changes on the process and effectiveness of treatment.

Center for Substance Abuse Prevention (CSAP)

CSAP will continue to utilize set-aside funding for the improvement of State prevention systems. CSAP has utilized the funds to develop and implement advanced prevention methodology for all components of State prevention systems, including systems for data collection and performance measurement. Specific examples of activities to be continued in FY 2001 include:

- State Needs Assessments

CSAP's State Needs Assessment Program has awarded 3-year contracts to 27 States over the past four years. The purpose of the program is to assist States increase their ability to base their prevention programming, resource allocation, and performance measurement on scientifically sound quantitative data, and help improve the States' capacity and infrastructure to conduct studies and utilize data. States receiving contracts are required to conduct a core set of studies, including school-based, archival, and community resource assessments. This information has been invaluable, especially to those States which have received a State Incentive Grant award, as they begin to implement science-based prevention programs to address their critical capacity needs identified through these needs assessments.

- Prevention Technical Assistance (TA) to States

CSAP has provided TA activities to more than 45 States and U.S. jurisdictions to support their substance abuse prevention systems. TA has been provided on-site, by phone, and in multi-State formats. Primary areas of assistance provided include: general TA (addressing prevention system infrastructure); youth tobacco control (helping States to develop tools and strategies to comply with the Synar regulation); minimum data set (promoting common data collection regarding service characteristics and populations served with a set of defined data elements); and State Incentive Grant support.

- Minimum Data Set Program

The CSAP Minimum Data Set (MDS) Program makes an economical, efficient, and user-friendly database management information system (MIS) available to State, sub-State, and local substance abuse prevention agencies and prevention service providers. The common data sets and definitions were developed through a consensus process with State officials and CSAP. The MIS is a PC-based software package for capturing, organizing, and reporting information on the populations served and substance abuse prevention services provided. The MIS is used on a voluntary basis to collect uniform information that informs prevention programming, resource allocation, process evaluation, measuring performance, and data sharing.

Center for Substance Abuse Treatment (CSAT)

CSAT responds to specific requests from State and Territory substance abuse directors for technical assistance to enhance their jurisdictions' capacity to deliver effective treatment services, or to better manage relevant data in order to monitor outcomes. Some examples of projects funded by CSAT's allocation of the SAMHSA set-aside are:

- Fourteen State contracts for Treatment Outcomes and Performance Pilot Studies (TOPPS), which address issues needed to improve system capability, standardization, and accountability through better defined and validated measures of substance abuse treatment outcomes and performance measures. New cooperative agreements (TOPPS-II), awarded in September, 1998, will assist States in refining management information systems to systematically monitor common substance abuse treatment effectiveness data measures on both a State and inter-State basis.

- Phase I of the State needs assessment contracts were awarded to 53 states and Territories by the end of 1997, with additional awards initiated to assist all Pacific island jurisdictions in enhancing their data collection, analysis and management capabilities. Some States are now using data generated from the needs assessments for re-direction of State funds and measurement of services impact. States are also using needs assessment findings to guide their initial efforts at introducing and monitoring managed care activities. For example:

  - Several States (MI, IL, WA, TX, MN, IO, AZ) are now using findings to inform their States' policy and budgeting development processes as well as to change their resource allocation methodologies and funding patterns. Illinois has used its needs assessment data to develop a new methodology for re-allocating funds among its regions as the Single State Authorities (SSA) develops new contracts with managed care organizations. Arizona, Colorado, North Carolina, and Texas are also using the data for these purposes.

  - Iowa has used the findings of its study of alcohol and drug use among women, age 18 and over, to redesign the State's approach to providing tailored outreach and treatment services for women. The study found that a very low proportion of those needing treatment ever received it (less than 5%), and identified some significant barriers to entering and remaining in treatment. These were: financial concerns, concerns about confidentiality and stigma, and lack of child care.

  - New Jersey has used the results from several of its studies to guide the allocation among treatment programs of over $10 million in new funds. New Jersey's data are also now being used by county level decision makers as they do their annual contracting with providers.

- Phase II of the State Treatment Needs Assessment Program (STNAP) began in 1997 and twenty seven States have received contracts. The second phase will allow repeats of some studies to get trend data as well as to carry out more sophisticated gap analyses. In response to the planned expansion of the National Household Survey on Drug Abuse (NHSDA) to provide State-level estimates of prevalence,

CSAT has been collaborating with ONDCP and OAS to have the National Household Survey on Drug Abuse become the general population survey used by the States in conducting their treatment needs assessments. CSAT anticipates that the NHSDA will replace the individual State adult and adolescent telephone household surveys and school surveys now supported through STNAP.

- Arizona and several other States are conducting a comparison of their findings with NHSDA. The findings will serve as checks on the reliability and validity of the two different interview modalities used. Comparisons are now somewhat more relevant because the NHSDA's increased sample size makes regional breakouts possible. Texas and several other States have offered to serve as pilots for this approach substituting the NHSDA for their own State telephone household and school surveys to produce prevalence estimates that can be combined with State-conducted special population and social indicator studies to yield relevant small area estimates. States are likely to choose to analyze the NHSDA results only once every 4-5 years, aggregating the yearly samples to ensure a large-enough sample size to do small area estimates and gap analysis.

Other activities, notably collaborative initiatives and training-related projects, which are being supported by CSAT are:

- Collaboration with CMHS and CSAP, the SAMHSA Office of Managed Care and with HCFA in planning training symposia nationwide for all State and mental health directors, and State Medicaid directors, on the use of a guide for substance abuse public purchasers of managed care services: ***"Contracting for Managed Substance Abuse and Mental Health Services."*** The Guide was recently developed and published as TAP # 22 in the CSAT Technical Assistance Publication series.

- The Treatment Improvement Protocols (TIPS) series, which provide state-of-the-art consensus documents on a variety of current topics in the treatment field. To date, 29 TIPS have been published and disseminated to the field. A 4-year evaluation of the TIPS was begun in 1997 to assess their impact on the field.

- State Team Building Workshops on the new Temporary Assistance to Needy Families (TANF) laws. All Single State Authorities (SSAs) and representatives from state welfare offices have attended such conferences, during which they learn from each other and help coordinate the development of their own State plans. The State evaluations of this effort have been exceptional.

F. PROGRAM MANAGEMENT

Authorizing Legislation - Section 301 and Section 501 of the Public Health Service Act

	1999 Actual	2000 Pre-recission Appropriation	2000 Final Appropriation	FY 2001 Estimate	Increase or Decrease
BA	$56,517,000	$59,100,000	$59,054,000	$59,943,000	+$889,000
FTE	520	559	559	559	---

2001 Authorization

PHSA Section 301/501 . . . . . Indefinite

Purpose and Method of Operation

The Program Management activity includes resources for coordinating, directing, and managing the Agency's programs, as well as related overhead costs. Direct support is provided for each of the three SAMHSA Centers, the Office of the Administrator (OA), the Office of Applied Studies (OAS), and the Office of Program Services (OPS). Over 94 percent of program management funds are committed to fixed costs, with 76 percent of the total dedicated to salaries and benefits and 18 percent to rent, overhead, and workers' compensation payments. The remaining covers minimal travel, training, and administrative purchases.

Funding and staffing levels for the past five fiscal years were as follows:

	Funding	FTE
1996	$56,118,000	587
1997	55,331,000	552
1998	55,400,000	549
1999	56,517,000*	520
2000	59,054,000	559

*Includes $3,117,000 in reprogrammed funds to support program management in FY 1999.

Rationale for the Budget Request

The FY 2001 request includes a net increase of $0.9 million for mandatory cost increases. Built-in increases total $4.1 million, so the balance will be absorbed through decreases in other cost categories.

The FY 2001 Program Management budget will support 559 FTEs, the same number as in FY 2000. Sufficient numbers of staff will be dedicated to new initiatives, such as the mental health School Violence program. In FY 2001 Agency staff will continue to address such key issues as translating best practices into service delivery; analyzing data results from the National Household Survey, TOPPS II, voluntary Block Grant data reporting, and other sources; emphasizing outcome measurement and accountability as required by the Government Performance and Results Act; and managing the new and expanded activities described for FY 2001.

Full-Time Equivalent (FTE) Employment

	FY 1999 Actual	FY 2000 Estimate	FY 2001 Estimate	Increase or Decrease
FTE/Program Management	520	559	559	—
Block Grant Set-Aside .	39	53	53	—
Reimbursable Non-Exempt	2	2	2	—
Reimbursable Exempt SEH	71	72	72	—

Increases:

Built-in:	
Annualization of 2000 pay costs	+$638,000
Within grade pay increases	+ 930,000
Increase for January 2001 pay raise at 3.7% . .	+1,512,000
Increased rental payments to GSA	+315,000
Increase in overhead charges	+707,000
Total, Built-in	+$4,102,000
Total, Increases	+$4,102,000
Decreases:	
One day less pay	-$199,000
Program reductions from absorption of built-in mandatory increases	-3,014,000
Total, Decreases	-$3,213,000
Net Change:	+$889,000

Substance Abuse and Mental Health Services Administration
Detail of Full-Time Equivalent Employment (FTE)

	1999 Actual	2000 Estimate	2001 Estimate
Office of the Administrator	72	79	79
Office of Applied Studies	29	34	34
Office of Program Services	97	104	104
Center for Mental Health Services	123	136	136
Center for Substance Abuse Prevention	124	130	130
Center for Substance Abuse Treatment	116	131	131
Total, SAMHSA	561	614	614

Average GS Grade
- 1996.....11.04
- 1997.....11.04
- 1998.....11.70
- 1999.....11.67
- 2000.....11.67
- 2001.....11.90

Substance Abuse and Mental Health Services Administration
Detail of Positions

	1998 Actual	1999 Actual	2000 Estimate	2001 Estimate
Executive Level I	---	---	---	---
Executive Level II	---	---	---	---
Executive Level III	---	---	---	---
Executive Level IV	1	1	1	1
Executive Level V	---	---	---	---
Subtotal	1	1	1	1
ES-6	3	3	3	3
ES-5	1	2	3	3
ES-4	5	3	3	4
ES-3	---	1	1	1
ES-2	1	---	1	1
ES-1	2	2	2	2
Subtotal	12	11	13	14
GM/GS-15	62	65	65	68
GM/GS-14	112	140	122	130
GM/GS-13	151	164	158	165
GS-12	37	40	33	36
GS-11	19	20	13	17
GS-10	3	4	4	4
GS-9	24	30	25	30
GS-8	23	22	22	25
GS-7	53	55	51	60
GS-6	23	20	15	20
GS-5	11	7	5	5
GS-4	4	5	6	4
GS-3	---	---	---	---
GS-2	1	---	---	---
GS-1	1	1	1	1
Subtotal	524	573	520	565
CC-08/09	---	---	---	---
CC-07	---	1	1	1
CC-06	18	18	18	18
CC-05	7	7	7	7
CC-04	5	3	5	5
CC-03	2	2	2	2
CC-02	1	1	1	1
CC-01	---	---	---	---
Subtotal	33	32	34	34
TOTAL Full-Time Equivalent	570	617	614	614
Full-Time Equivalent Usage	551	563	584	614
Average GS Grade	11.70	11.67	11.67	11.90

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

DRUG ABUSE BUDGET

I. RESOURCE SUMMARY

(Budget Authority in Millions)

	1999 Actual	2000 Enacted	2001 Request
Drug Resources by Goal			
Goal 1	$440.160	$432.256	$431.984
Goal 2	12.100	---	---
Goal 3	1,029.734	1,090.447	1,164.438
Total	$1,481.994	$1,522.703	$1,596.422
Drug Resources by Function			
Prevention	$440.160	$432.256	$431.984
Treatment	1,041.834	1,090.447	1,164.438
Total	$1,481.994	$1,522.703	$1,596.422
Drug Resources by Decision Unit			
Knowledge Development and Application Program	192.888	159.800	145.281
Substance Abuse Prevention (Non-add)	*(77.591)*	*(59.541)*	*(50.022)*
Substance Abuse Treatment (Non-add)	*(115.297)*	*(100.259)*	*(95.259)*
Targeted Capacity Expansion Program	133.307	194.590	248.368
Substance Abuse Prevention (Non-add)	*(78.218)*	*(80.283)*	*(85.207)*
Substance Abuse Treatment (Non-add)	*(55.089)*	*(114.307)*	*(163.161)*
High Risk Youth Program	6.991	7.000	7.000
National Data Collection *	---	---	12.000
Substance Abuse Block Grant (SAPTBG)	1,126.460	1,137.120	1,159.152
Program Management	22.348	24.193	24.621
Total	$1,481.994	$1,522.703	$1,596.422
Drug Only Funding (Non-add)	*($1,187.659)*	*($1,225.583)*	*($1,293.545)*
Alcohol / Drug Co-Morbid -- SAPTBG (Non-add)	*(225.863)*	*(228.000)*	*(232.418)*
Alcohol Under Age 21 -- SAPTBG (Non-add)	*(68.472)*	*(69.120)*	*(70.459)*
Total Drug Abuse, Incl Alcohol-Related (Non-add)	*($1,481.994)*	*($1,522.703)*	*($1,596.422)*
Drug Resources Personnel Summary			
Total FTEs	276	312	312
Information			
Total Agency Budget	$2,486.787	$2,651.868	$2,835.016
Drug Percentage	59.59%	57.42%	56.31%

* FY 2001 reflects $12.0 million to be transferred to SAMHSA from the Department of Health and Human Services' evaluation resources to support the National Household Survey on Drug Abuse (NHSDA).

II. METHODOLOGY

- Funding for SAMHSA's Substance Abuse Prevention and Treatment Knowledge Development and Application (KD&A) activities is considered to be 100 percent drug-related.

- Funding for SAMHSA's Substance Abuse Prevention and Treatment Targeted Capacity Expansion (TCE) activities is considered to be 100 percent drug-related.

- Funding for SAMHSA's substance abuse prevention High Risk Youth (HRY) program is considered to be 100 percent drug-related.

- Funding for the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) is considered drug-related to the extent that these funds are used by the States/Territories for treatment and prevention of the use of illegal drugs and used by the Agency for technical assistance, data collection, and program evaluation. SAMHSA has continued to use the methodology in estimating drug related activities consistent with the earmarks required by P.L. 102-321.

- Five percent of the block grant is required to be used for set-aside activities which support data collection, technical assistance, and program evaluation. The remaining 95 percent is distributed to the States and Territories where at least: 35 percent must be used for alcohol prevention and treatment activities; 35 percent must be used for other drug prevention and treatment activities; and, the remaining 30 percent is to be used at State discretion, either for alcohol alone, for drugs alone, or shared by both alcohol and drug programs. For budget formulation purposes, SAMHSA and ONDCP agreed to score the discretionary amount equally for alcohol and drugs, with 15 percent assigned to alcohol programs and 15 percent assigned to drug programs.

- Funding for SAMHSA's Office of Applied Studies (OAS) substance abuse surveys/data collection activities is considered to be 100 percent drug-related.

- Funding for Program Management activities is considered drug-related to the extent that funds are used to support the operations of the Center for Substance Abuse Treatment (CSAT), the Center for Substance Abuse Prevention (CSAP), and the activities of the Office of Applied Studies (OAS) that are supported by set-aside funds from the Substance Abuse Prevention and Treatment Block Grant (SAPTBG).

III. PROGRAM SUMMARY

Goal 1: Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.

- Financial support for this goal includes funding for prevention Knowledge Development and Application (KD&A) programs, prevention Targeted Capacity Expansion (TCE) programs, the High Risk Youth Program, data collection activities (administered by OAS), and 20% of the Substance Abuse Prevention and Treatment Block Grant, as well as program support for these activities.

- Funding for prevention KD&A programs supports defined population studies to field test controlled study findings under varying real-world conditions and with diverse populations. Prevention programs involve developing and assessing new and emerging prevention methodologies and approaches; collecting, analyzing, and synthesizing prevention outcome knowledge, and monitoring national trends in substance abuse and emerging issues. Knowledge development programs develop knowledge about prevention strategies effective across the life-span, with specific programs targeting early childhood, children and their families, adults, and the elderly. After field testing promising approaches in knowledge development programs, emphasis shifts to the synthesis and dissemination of the knowledge gained from these final study phases to the practical application of these strategies by States and local communities. Knowledge application programs help substance abuse prevention practitioners and policy makers in States and communities systematically deliver and apply skills, techniques, models, and approaches to improve substance abuse prevention services. In the aggregate, CSAP's knowledge application programs complete the research to practice continuum by synthesizing and translating scientific findings into useable knowledge, programs and packages, disseminating that knowledge widely, and helping States, communities and individuals to adopt and use it to meet local needs.

- The Federal Drug Free Workplace (DFWP) and National Laboratory Certification (NLCP) Programs reduce adult substance abuse demand in the Federal service and promulgate scientific and technical guidelines for Federal employee drug testing programs. NLCP certifies drug testing laboratories, provides guidance for self-sustaining drug testing programs, and is the Federal focal point for developing and implementing non-military, Federal workplace drug testing technical, administrative and quality assurance programs.

- Funding for prevention Targeted Capacity Expansion (TCE) programs supports efforts designed to address the specific and immediate prevention service capacity needs within the States and communities. TCE programs represent a comprehensive effort to improve the quality and availability of effective research-based prevention services and to help States and communities address and close gaps in prevention services which often cannot be addressed via the block grant funding process. With primary foci on improving capacity and fostering the use of current "best practices" in actual service systems, these programs assure the consistency and nature of services delivered and enable the collection of client outcome data--characteristics not available in Federal block-grant supported services. TCE provides a mechanism to support limited, but targeted, services in discrete areas of unmet or emerging local needs made apparent from epidemiological data, from local experience, or created as a result of local, State or national social policy change.

- Funding for High Risk Youth (HRY) supports testing of a wide variety of interventions to prevent substance abuse among children and youth. Building on projects that have been comprehensive and have focused on the major domains--individual, family, school, peers, community -- which impact the life of a child and based on knowledge gained from CSAP and other research efforts, a new program targeting high-risk youth was initiated in FY 1998. This program focuses, in particular, on youth who are at high risk for becoming substance abusers and/or involved in the

juvenile justice system. Specifically, the new HRY - Project Youth Connect program targets youth ages 9-11, and those ages 12-18, and seeks to intervene with these youth while they are at a period in their lives when positive influences can still have an effect. Mentoring as a substance abuse prevention strategy is featured in this program.

< SAPTBG activities include State expenditures of 20% of their block grant allotment for prevention services as well as 20% of the block grant set-aside for the collection and analysis of national data, the development of State data systems (including the development and maintenance of baseline data on the incidence and prevalence as well as the development of outcome measures on the effectiveness of prevention programs), provision of technical assistance, and program evaluations. Also, this program supports oversight of Synar Amendment implementation requiring States to enact and enforce laws prohibiting the sale and distribution of tobacco products to persons under 18 so as to reduce the availability of tobacco products to minors.

Goal 2: Increase the safety of America's citizens by substantially reducing drug-related crime and violence.

C Financial support for this goal includes criminal justice-related treatment funding from the treatment Knowledge Development and Application program (KD&A), as well as program support for these activities, through 1999. Funding for treatment KD&A programs includes continuation of pre-1996 demonstration awards for criminal justice programs (adult, juvenile, institutional, and community based). The authorities for these programs have expired. The remainder of the treatment KD&A portfolio, to include those projects in support of treatment in the criminal justice system, are found in CSAT knowledge development and application programs (KD&A).

Goal 3: Reduce health and social costs to the public of illegal drug use.

C Financial support for this goal includes funding for treatment Knowledge Development and Application programs (KD&A), Targeted Capacity Expansion (TCE) programs, and 80% of the Substance Abuse Prevention and Treatment Block Grant, as well as program support for these activities.

< Funding for treatment KD&A programs includes continuation of pre-1996 demonstration awards including funding for the Target Cities program, women and children programs (Pregnant and Postpartum Women, Residential Treatment for Women and Children), Critical Population programs, AIDS program (linkage, outreach), and training programs. The authorities for these programs have expired. The remainder of the treatment KD&A portfolio includes knowledge development and application activities to: bridge the gap between knowledge and practice; promote the adoption of best practices; and assure services availability/meet targeted needs.

< Targeted Capacity Expansion (TCE) programs have been established to focus more funding toward decreasing the substance abuse treatment gap. Initially, treatment TCE activities were funded as part of the treatment KD&A program, but in the year 2000, Targeted Capacity Expansion programs are reflected as a separate line item in the SAMHSA budget. The Targeted

Capacity Expansion program is designed to address gaps in treatment capacity by supporting rapid and strategic responses to demand for alcohol and drug abuse treatment services. The response to treatment capacity problems may include communities with serious, emerging drug problems or communities struggling with unmet need. In 1999, these programs included an HIV/AIDS component targeting minority populations at risk of contracting HIV/AIDS or living with HIV/AIDS. The goal of this aspect of the TCE program is to enhance and improve existing substance abuse treatment services for minority populations in cities and States highly impacted by the twin epidemics of substance abuse and HIV/AIDS.

< SAPTBG activities include State expenditures of 80% of their block grant allotment for treatment services as well as CSAT and OAS expenditures of 80% of the block grant set-aside for the collection and analysis of national data, the development of State data systems (including the development and maintenance of baseline data on the incidence and prevalence as well as the development of outcome measures on the effectiveness of treatment programs), provision of technical assistance, and program evaluations.

IV. BUDGET SUMMARY

2000 Program

C The 2000 appropriation supports a drug abuse budget of $1.482 billion, or an increase of $40.7 million over the prior year. This includes $432.3 million for Goal 1 (Prevention) activities, and $1.09 billion for Goal 3 (Treatment) activities. Activities in support of Goal 2 (Corrections) are not funded in the 2000 budget. It should also be noted that SAMHSA's substance abuse KD&A program has been reduced by $33.1 million from the 1999 level.

Goal 1: Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.

C CSAP proposes the following new initiatives/program expansions in support of Goal 1 in FY 2000:

< $12 million of the funds available in FY 2000 will be used to support four new **State Incentive Grants**. Funding will enable States to examining their State prevention systems and redirecting State resources to critical targeted prevention service needs within their states. This expansion is consistent with the Office of National Drug Control Policy language calling for a SIG grant in every State by the year 2003. This will bring the SIG program to approximately 25 of the 60 States and Territories by FY 2000.

< CSAP will also contribute to the SAMHSA crosscutting initiatives on Underage Drinking and Women with Histories of Violence. The **National Agenda Against Underage** Drinking program seeks to identify preventive interventions that enhance protective factors and/or reduce risk factors and are effective in reducing underage alcohol use and its associated health and social problems among youth (ages 9-21) in a variety of settings. This initiative will fund approximately six to eight three-year projects to replicate specified program models (maintaining program fidelity) in new settings to expand testing of the intervention to specific populations. The **Women with Alcohol,**

Drug Abuse, and Mental Health Disorders Who Have Histories of Violence program will develop an integrated system of care with services intervention models and qualitative evaluations followed by full scale implementation of integrated strategies and services intervention models and outcome evaluations. Building on SAMHSA's previous gender specific efforts with women, this initiative seeks to discover what works to improve women's outcomes in the utilization of substance abuse and mental health treatment services and to promote the improved coordination of services by developing an integrated services approach to organizing and institutionalizing coordinated social service delivery systems. The initiative will address the unique needs of under served populations, including African Americans, Latinos/Hispanics, American Indian/Alaska Natives, immigrants and women with disabilities.

Goal 3: Reduce health and social costs to the public of illegal drug use.

C CSAT proposes the following new initiatives/program expansion in support of Goal 3 in FY 2000:

< The **Targeted Capacity Expansion** program was increased by $59.2 million for 2000. This funding will be used to award approximately 100 new grants, including the provision of treatment services for targeted minority populations at risk of contracting HIV/AIDS or living with HIV/AIDS. (These populations include substance abusing African American and Hispanic women and their children; substance abusing African American and Hispanic adolescent boys and girls; and substance abusing African American and Hispanic men.

< An increase of $15 million was provided for the **Substance Abuse Prevention and Treatment Block Grant** for a total of $1.6 billion in 2000. Of this total amount, $1.137 billion is scored for drug abuse prevention and treatment activities. The SAPT Block Grant is a formula grant, and it is the cornerstone of the States' substance abuse programs, accounting for approximately 40% of public funds expended for treatment and prevention (1995).

< **Underage Drinking Initiative (KD&A):** CSAT's primary role in the **National Agenda Against Underage Drinking** will be related to the generation of new empirical knowledge about what brief intervention and treatment models and associated services are most effective for treatment of alcohol use, misuse, and abuse in the cited underage populations.

< **Violence Against Women Initiative (KD&A):** The activities included in this initiative will build on SAMHSA's previous gender specific treatment efforts with women. This initiative seeks to discover what works to improve women's outcomes in the utilization of substance abuse treatment services and to promote the improved coordination of services by developing an integrated services approach to organizing and institutionalizing coordinated social service delivery systems.

2001 Request

C A total of $1.596 billion is requested for the drug abuse budget in 2001, representing an increase of $73.7 million over the 2000 Enacted budget. This includes an increase of $53.8 million for Targeted Capacity Expansion initiatives; an increase of $22 million in the drug abuse-related

portion of the Substance Abuse Prevention and Treatment Block Grant; and, $12 million for National Data Collection. These increases are partially offset by a combined decrease of $14.5 million in the prevention and treatment Knowledge Development and Application activities.

Goal 1: Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.

C CSAP proposes the following program expansions in support of Goal 1 in FY 2001:

< **Community Initiated Prevention Intervention Program**. New in FY 1999, this program tests effective substance abuse prevention interventions that have been shown to prevent or reduce alcohol, tobacco, or other illegal drug use as well as associated social, emotional, behavioral, cognitive and physical problems among at-risk populations in their local communities. The program is determining the most effective prevention intervention models and associated services for preventing, delaying and/or reducing substance use and abuse by at-risk populations and measuring and documenting reductions in substance abuse and associated problems as compared to comparison groups. Importantly, these grants are using findings and outcomes from prior CSAP programs, building the knowledge base and improving practice. This program will be expanded as funds are available in FY 2001.

< In FY 2001, as part of this Substance Abuse and Violence Prevention Initiative, CSAP proposes to conduct an expansion of the **High Risk Youth** Project Youth Connect program to address the positive effects of an afternoon mentoring and tutoring beyond the classroom that will test the effectiveness of a set of structured one-on-one and group mentoring initiatives implemented in specific settings. The core of these programs will have community volunteer organizations, such as community coalitions and faith organizations, develop comprehensive afternoon programs that foster increased involvement of youth with caring, prosocial adults. The one-on-one mentors will be matched with youth identified as being at greatest risk for substance use and other problem behaviors.

< Finally, in FY 2001, CSAP will fund approximately 16 new **State Incentive Grants,** ensuring that all states receive a SIG award by 2002. Funding will enable States to examine their State prevention systems and redirect State resources to critical targeted prevention service needs within their state. This expansion is consistent with the ONDCP Performance Measures of Effectiveness which call for a SIG grant in every State by the year 2002.

Goal 3: Reduce health and social costs to the public of illegal drug use.

C CSAT proposes the following new initiatives/program expansion in support of Goal 3 in FY 2001:

< CSAT proposes to fund approximately 70 new **Targeted Capacity Expansion (TCE)** projects which focus on development of creative and comprehensive drug and alcohol early intervention and treatment systems for adults and adolescents in small towns, rural areas, and mid-size cities. In addition to youth, other populations targeted by this program would include women, homeless, co-morbid, rural, and poly-substance abusers.

< CSAT proposes further expansion of the efforts begun by the Congressional Black Caucus in FY 1999, focusing on enhanced and expanded substance abuse treatment services related to HIV/AIDS in African-American, Hispanic and other racial/ethnic minority communities. Approximately 33 new **TCE-HIV/AIDS** grants will be funded.

< In support of the National Drug Control Strategy goal of closing the drug treatment gap, CSAT proposes an increase of $31 million in the **Substance Abuse Prevention and Treatment Block Grant** in FY 2001.

< In addition, CSAT and SAMHSA's Office of Applied Studies (OAS) will collaborate on the continuing development and implementation of a National Treatment Outcomes Monitoring System (NTOMS) in compliance with the ONDCP *National Drug Control Strategy, 1999*, Goal 3, Objective 1, Target 4: *Implement NTOMS*. This effort will also involve coordination with a number of other Departments, including the Department of Veterans Affairs and the Department of Justice. The first-year (2001) costs of NTOMS are estimated at $5 million, to be funded from the SAPT Block Grant set-aside. Set-aside funding will be available for NTOMS, as a result of SAMHSA's receipt of a $12 million allocation from the Secretary's 1% evaluation resources to partially fund the National Household Survey on Drug Abuse (NHSDA). (In 1999, and again in 2000, the NHSDA will only be funded from the Block Grant set-aside, significantly reducing fund availability for other authorized activities.)

V. PROGRAM ACCOMPLISHMENTS

C The ***Workplace and Managed Care Program*** is identifying the managed care models that perform well in the workplace to prevent and treat substance abuse. Studies found that females, workers over age 30, and workers with lower earnings were more likely to have one or more substance abuse/mental health related health care claims. These findings are helping to identify those segments of the workforce toward which future prevention efforts should be targeted. Another study is finding that the workplace is an appropriate context in to which to (1) disseminate information to parents on substance abuse, youth risk and protective factors, and parenting strategies; (2) increase parents' confidence in helping youth avoid substance abuse problems; and (3) develop prevention strategies for parents to implement, suggesting future program directions.

C ***National Center for the Advancement of Prevention (NCAP)***. Among NCAP products are Technical Reports on such topics as *Alternative Activities and Alternatives Programs in Youth-Oriented Prevention* and *Strategies for Reducing Sales of Tobacco Products to Minors*; Implementation Guides on *Effective Community Mobilization* and *Tobacco Outlet Inspections*; and Resource Papers such as the AESOP *Overview of the Science and Models of Prevention*. Products have been used to bolster CSAP training and technical assistance activities, to improve CAPT efforts and to change/improve program strategies and effectiveness in the field.

C ***National Clearinghouse for Alcohol and Drug Information (NCADI)*** is the largest information clearinghouse in the country for alcohol and drug information. It responds to about

200,000 information requests annually and distributes over one million free or at-cost Federal publications, audiotapes, and videotapes per month. The level of demand for NCADI services during a typical month is reflected in the following profile: 33,316 requests/month; 59 percent of inquiries are made by phone; 3 percent by mail; 30 percent by e-mail; and 2 percent by fax/in-person. NCADI has been the national resource for consumer materials for ONDCP's National Youth Anti-Drug Media Campaign that was launched in mid 1998. Infrastructure support provided included a toll-free number, extended hour phone coverage, and provision of bulk quantities of materials (1,050 tons in 1998) to respond to campaign-generated requests. After the first two weeks of the campaign, the NCADI contract experienced a 121 percent increase in caller volume as a result of the media advertising in 75 media markets. Hits to the NCADI website, Prevline, now exceed 4 million per month;

C ***Girl Power!.*** Girl Power! messages and materials have reached more than 100 million people; dozens of communities and a total of 59 national organizations mobilized to incorporate Girl Power! Into their programs across the country. Through May 1999, there were more than 12 million hits on the Girl Power! website with more than 36,000 occurring every day. To date, the number of Girl Power! stories, website hits, and products distributed have reached almost 15 million. Through partnerships with the Women's National Basketball League, Avon Corporation, the Girl Scouts of the U.S.A. and other national, State, and local organizations, Girl Power! is helping girls focus on their future aspirations and their physical and mental well-being.

C In an unprecedented effort to improve the availability, accessability, and quality of substance abuse treatment services nationwide, CSAT has launched a new initiative, ***Changing the Conversation: A National Plan To Improve Substance Abuse Treatment.*** The initiative involves a comprehensive analysis of five specific areas related to funding for and access to service delivery systems, public attitudes and beliefs, and best practices and treatment methods for addressing substance abuse. A series of stakeholder meetings and public hearings (in Hartford, CT; Chicago, IL; Washington, DC; Portland, OR; and Tampa, FL), have been conducted to address the five issue areas: closing the treatment gap; reducing stigma and changing attitudes; improving and strengthening treatment systems; connecting research and services; and, addressing workforce issues. Resource panels comprised of experts in the substance abuse treatment field have been formed to explore the current state of knowledge, resources, needs, and service and organizational capacity, and to recommend priorities for action by government and by other stakeholders in the substance abuse treatment field. The resource panel's final report, which will be published during FY 2000, will become the guide for CSAT's future program planning.

C CSAT's ***Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services*** seeks to address gaps in substance abuse treatment capacity and increase the accessability and availability of substance abuse treatment and related HIV/AIDS services (including sexually transmitted diseases (STDs), tuberculosis (TB), and hepatitis B and C) to African American, Hispanic/Latino, and other racial/ethnic minority substance abusers. Grantees are located within Metropolitan Statistical Areas (MSAs) with an annual AIDS case rate of 20 such cases per 100,000 individuals or States with an AIDS case rate of 10 such cases per 100,000 individuals. In FY 1999, CSAT made awards to 35 grantees in 14 States (AL; AZ; CA (8);

CT(2); DE; FL (3); HI; IL (4); MA (2); NJ; NY (5); RI; and TX (2)), the District of Columbia, and the U.S. Virgin Islands.

- CSAT's ***HIV/AIDS Outreach Program*** is designed to develop community-based outreach projects to provide HIV counseling and testing services, access to sexually transmitted disease (STD) and tuberculosis (TB) testing, substance abuse treatment, primary care, mental health and medical services for those who are HIV positive or have AIDS. The purpose of this program is to promote behavioral transition and change among injecting drug users (IDUs) and other at-risk drug users, and to increase the number of substance abusers entering treatment among African American, Hispanic/Latino, and other racial/ethnic minority populations in high AIDS case rate areas. Grantees are located within Metropolitan Statistical Areas (MSAs) with an annual AIDS case rate of 20 such cases per 100,000 individuals or States with an AIDS case rate of 10 such cases per 100,000 individuals. In FY 1999, SAMHSA/CSAT made awards to 25 grantees in 14 States (AL; AZ; CA(4); CT(2); GA; IL (3); MA; MD; MO; NE; NJ; NY (4); PA; TN) and Puerto Rico.

- CSAT and CMHS jointly awarded $5.0 million to the Alaska Department of Health and Social Services to fund an integrated services delivery system for **Co-Occurring Substance Abuse and Mental Health Disorders**, in Anchorage, Alaska. The program's four major goals are: to reduce the State's reliance on hospital-based emergency/crisis psychiatric and substance abuse emergency services by expanding community-based options for responding to individuals with co-occurring disorders who experience destabilization; to expand the capacity of both community-based mental health and substance abuse treatment systems to provide seamless treatment and support services within each system to individuals with co-occurring disorders; to evaluate the process of implementing a seamless model, including management of multiple funding streams; and, to evaluate the impact of the system changes on client utilization of mental health and substance abuse treatment services, primary health care, and other ancillary health and social services.

- CSAT and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) are jointly funding research which will contribute to the identification of efficacious treatment interventions and services for ***Adolescent Alcohol Abusers and Alcoholics***. Two types of studies have been funded: (1) those that are theory driven and based on experimental design (efficacy studies); and (2) those that assess practice as usual in health service settings (effectiveness studies). Projects may also identify, develop, and/or test related screening, assessment, and diagnostic instruments or may propose pretrial studies that investigate predictors of treatment outcomes in specific subgroups of adolescents. As of September 30, 1999, 14 grants (10 clinical studies and 4 questionnaire development projects) had been awarded to institutions of higher education in 8 States (CA; FL; KY; NM(2); OR; SC; WA(2)) and other health and human services institutions in 4 States (IL; MA(2); MD; and MN).

VI. PROGRAM STATISTICS

- Resource Summary - Detail by Goal and Objective (See Table)

- Treatment Gap (See Table)

C Persons Served (See Table)

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

I. RESOURCE SUMMARY - Detail by Goal and Objective
($ in millions)

	Program Title	Drug Related Percent	FY 1998 Actual	FY 1999 Actual
GOAL 1: Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.				
Impact Target a	YSAPI (Reduce Youth Past Mo Prevalence)	100.00	70.30	69.78
OAS/National Data Collection	National Household Survey on Drug Abuse	100.00	18.00	0.00
Objective 1	CSAP-SAPT Block Grant Set-aside *	100.00	13.10	12.36
	NCADI	100.00	5.40	5.72
	Strengthening Family Program	100.00	0.00	9.88
Subtotal			106.80	87.86
Objective 2				
Subtotal			0.00	0.00
Objective 3	Block Grant Prevention Portion	71.07	175.08	209.44
Subtotal			175.08	209.44
Objective 4				
Subtotal			0.00	0.00
Objective 5				
	High Risk Youth: Mentor Program	100.00	6.00	6.99
Subtotal			6.00	6.99
Objective 6				
	Community Partnerships	100.00	9.50	6.42
Subtotal			9.50	6.42
Objective 7				
	Materials Development/Media Literacy	100.00	2.00	1.50
Subtotal			2.00	1.50
Objective 8				
	HRY/SESS/Managed Care/Predictor Variables	100.00	34.83	36.64
Subtotal			34.83	36.64
Objective 9				
	COSAP/Teen Parents	100.00	13.00	12.90
Subtotal			13.00	12.90
Resources not aligned to an existing objective.	HHS/SAMHSA Taps, SAMHSA Crosscuts, Logis.	100.00	7.80	5.90
Drug Free Workplace	Workplace Program	100.00	7.37	7.41
Prevention Training	Faculty Development Program	100.00	0.80	1.10
Substance Abuse and Disease Prevention	HIV/AIDS Activities	100.00	0.00	8.44
Prevention Program Management	Program Management	100.00	12.36	12.21
OAS Surveys and Studies	OAS-SAPT Block Grant Set-aside *	100.00	27.45	43.34
Subtotal			55.78	78.41
Total for Goal 1			402.99	440.16
GOAL 2: Increase the safety of America's citizens by substantially reducing drug-related crime and violence.				
Objective 4	CJ Treatment Networks	100.00	8.20	8.10
	CJ Diversion	100.00	3.00	3.10
Subtotal			11.20	11.20
Objective 5				
	Drug Court Activities	100.00	0.46	0.90
Subtotal			0.46	0.90
Resources not aligned to an existing objective.			NA	NA
Total for Goal 2			11.66	12.10

I. RESOURCE SUMMARY - Detail by Goal and Objective (con't)
($ in millions)

	Program Title	Drug-Related Percent	FY 1998 Actual	FY 1999 Actual
GOAL 3: Reduce health and social costs to the public of illegal drug use.				
Objective 1	Targeted Capacity Expansion	100.00	24.73	39.47
	SAPT Block Grant	71.07	725.32	837.77
	Hotline	100.00	0.20	0.25
	Managed Care Activities	100.00	4.80	3.48
	CSAT-SAPT Block Grant Set-Aside Activities *	100.00	6.20	10.50
	Dissemination (Knowledge Application)	100.00	3.00	3.50
	National Leadership Institute	100.00	1.48	3.30
	Treatment Improvement Protocol Series (TIPS) *	100.00	1.80	0.00
	Treatment Improvement Protocol Series (TIPS)	100.00	0.00	0.80
	National Centers (GAINS, Advanced Tech Spt)	100.00	1.30	0.50
	Communication Activities	100.00	1.30	1.61
Subtotal			770.12	901.18
Objective 2				
	Cross-Training	100.00	0.59	0.13
	HIV/AIDS Activities	100.00	1.15	1.15
	Targeted Capacity Expansion - HIV/AIDS	100.00	0.00	15.83
	HIV/AIDS Outreach	100.00	0.00	2.05
Subtotal			1.74	19.16
Objective 3				
Objective 4	Addiction Technology Transfer Ctrs (ATTC)	100.00	7.55	7.92
	Training Activities	100.00	1.60	1.68
Subtotal			9.15	9.61
Objective 5				
	Exemplary Programs	100.00	2.12	4.60
	Methadone Accreditation	100.00	5.03	1.28
	Managed Care Studies	100.00	7.90	4.07
	Practice Research Collaborations	100.00	0.00	1.78
	Comprehensive Community Trmt (Women and Children, Rural, SSI, Co-occurring, Homeless, Domestic Violence, TANF, SESS)	100.00	40.96	39.41
	Special Drug Studies (Alcohol, Methamphetamine and Marijuana)	100.00	10.00	8.10
	CSAT Data (NEDS)	100.00	2.70	2.77
Subtotal			68.71	62.01
Objective 6				
	Treatment Episode Outcomes	100.00	2.00	0.00
	Persistent Effects of Treatment Study	100.00	7.20	0.00
	Managed Care Evaluation	100.00	1.47	0.17
	Needs Assessment *	100.00	7.00	3.02
	Needs Assessment	100.00	2.34	0.00
	Cost Profiles	100.00	1.46	0.00
	National Health Spending *	100.00	0.96	0.77
	TOPPS II *	100.00	9.00	9.05
	TOPPS II (Monitoring)	100.00	0.00	0.68
Subtotal			31.42	13.69
Objective 7				
Subtotal			0.00	0.00
Resources not aligned to existing objective	HHS/SAMHSA Taps, SAMHSA Crosscuts, Logis.	100.00	9.68	9.83
Community Support	Recovery Community Support Program (RCSP)	100.00	3.66	4.13
Treatment Program Management	Program Management	100.00	10.90	10.14
Subtotal			24.23	24.09
Total for Goal 3			905.37	1,029.73
Grand Total			1,320.02	1,481.99

Footnotes
NA Not Applicable

***** Identifies Substance Abuse Prevention and Treatment (SAPT) Block Grant Set-aside Funding.

The grand total of all block grant dollars on this table will not agree with the total SAPT Block Grant, as appropriated. For the Drug Abuse Budget, SAMHSA does not score funding for persons who only abuse alcohol. However, programs that involve abuse of alcohol and other drugs together, or illegal use of alcohol by persons under age 21, are scored for the Drug Abuse Budget.

Estimates of Number of Persons Needing and Receiving Treatment for Drug Abuse Problems: NHSDA 1991-97

	Number of Persons (in 1,000's)						
	1991	1992	1993	1994	1995	1996	1997
Total Drug Abuse Treatment Need	8,991	8,599	8,067	8,329	8,906	9,383	9,474
Level 1 Treatment Need							
Persons with Less Severe Problems Needing Treatment	3,843	3,881	3,326	3,719	4,260	4,080	3,748
Level 2 Treatment Need							
Persons with Severe Problems Needing Treatment	5,148	4,718	4,741	4,610	4,646	5,303	5,726
Persons Receiving Treatment	1,649	1,814	1,848	1,984	2,121	1,973	2,137
Percent of Level 2 Treated	32%	38%	39%	43%	46%	37%	37%
Percent of Level 2 Not Treated	68%	62%	61%	57%	54%	63%	63%
Treatment Gap	3,499	2,904	2,893	2,626	2,525	3,330	3,589

Note: Estimates for 1991-97 are ratio-adjusted to partially account for underestimation due to underreporting and undercoverage in the NHSDA. Estimates for 1991-93 are also adjusted for trend consistency, to account for the change in the NHSDA questionnaire in 1994. Adjustment factors for trend consistency were 1.19020 for total treatment need and 1.21125 for Level 2 treatment need.

Source: Office of Applied Studies, SAMHSA. Unpublished data from the National Household Survey on Drug Abuse and Uniform Facility Data Set.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Number of Persons Receiving Treatment with SAMHSA Funding

(Treatment Funding Dollars in Thousands)

	1999 Actual	2000 Enacted	2001 Pres Budget	Increase in $ / Pers Svd 2001 vs 2000	Percent Increase 2001 vs 2000
SAMHSA Drug Treatment Funds	$919,273	$973,659	$1,036,877	$63,218	6.49%
Average Cost--Per Person/Per Year	$2,388	$2,445	$2,504	$59	2.40%
Persons Served w/ SAMHSA Funds	385,020	398,241	414,158	15,917	4.00%
KD&A Programs	*24,145*	*26,250*	*19,025*	*(7,226)*	*-27.52%*
Targeted Capacity Programs	*23,073*	*41,007*	*65,171*	*24,164*	*58.93%*
SAPT Block Grant Programs	*337,802*	*330,984*	*329,962*	*(1,021)*	*-0.31%*

Footnotes:

1/ Studies have shown that the SAPT Block Grant-funded portion of all publicly-funded treatment is approximately 40 percent of the total. By leveraging States and local governments to continue contributing their 60 percent share of publicly-funded treatment, the number of persons treated would be as shown in the table to the right.

Publicly-Funded Treatment - 2001		
Source	**Increase**	**Total**
Fed - SAPT	(1,021)	329,962
Fed - Other	16,938	84,196
State/Local	(1,532)	494,943
Total	**14,384**	**909,101**

2/ 1999 funding has been revised to reflect reprogramming actions, an HHS 1% transfer, and the 1999 rescission.

3/ The Average Cost Per Person/Per Year has been adjusted to reflect the most current CPI-U data.

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Substance Abuse and Mental Health Services Administration
HIV/AIDS Budget

(Dollars in thousands)

	FY 1999 Actual	FY 2000 Estimate	FY 2001 Request
Knowledge Development and Application	$9,285	$9,151	$8,935
Mental Health (Non-add)	*(8,265)*	*(8,001)*	*(7,985)*
Substance Abuse Prevention (Non-add)	---	---	---
Substance Abuse Treatment (Non-add)	*(1,020)*	*(1,150)*	*(950)*
Targeted Capacity Expansion	27,821	49,711	64,711
Substance Abuse Prevention (Non-add)	*(9,435)*	*(9,500)*	*(9,500)*
Substance Abuse Treatment (Non-add)	*(18,386)*	*(40,211)*	*(55,211)*
Substance Abuse Block Grant (Set-aside)	54,208	54,150	54,150
Program Management	580	580	580
Total, SAMHSA	$91,894	$113,592	$128,376

Substance Abuse and Mental Health Services Administration

HIV/AIDS by Functional Category

(Dollars in thousands)

Functional Categories	FY 1999 Actual	FY 2000 Estimate	FY 2001 Request
II. Risk Assessment and Prevention:			
C. Information and Education/Preventive Services:			
1. High risk or infected persons:			
a. Health education/risk reduction	$10,236	$11,304	$13,801
Subtotal, High Risk or Infected Persons	10,236	11,304	13,801
5. Health-care workers and providers	3,640	3,109	1,585
Subtotal, Information and Educ./Preventive Services	13,876	14,413	15,386
Total, Risk Assessment and Prevention	13,876	14,413	15,386
IV. Clinical Health Services Research and Delivery:			
A. Services:			
1. Community and mental health center services	3,824	3,089	2,100
3. Substance abuse treatment improvement program	74,194	96,090	110,890
Subtotal, Services	78,018	99,179	112,990
Total, Clinical Health Services Res. and Delivery	78,018	99,179	112,990
Total, SAMHSA	$91,894	$113,592	$128,376

Substance Abuse and Mental Health Services Administration
HIV/AIDS ACTIVITIES

Overview

Reports on HIV infection in the United States suggest that more than 50 percent of new HIV cases are directly or indirectly related to injecting drug use. This underscores the urgency in addressing the dual epidemics of substance abuse and HIV/AIDS. Current estimates suggest that there are more than 21 million substance abusers in this country. The National Institute on Drug Abuse estimates that there are approximately 1.5 million injecting drug users, many of whom are multiple drug users. In addition, the sexual partner(s) and unborn children of injecting drug users are at great risk of exposure to HIV infection. Of newly diagnosed adult/adolescent cases of AIDS between July 1998 and June 1999 and , 23% were directly attributable to injection drug use (IDU). However, among minority men the percentage of IDU related AIDS cases exceeded 31%. An additional 4% of new cases were attributable to injection drug use among men who have sex with men (MSM).

The status of the HIV/AIDS epidemic is a continuous severe and ongoing crisis remains vitually unchecked in communities of color, and especially in the African American and Hispanic communities. The burden of HIV/AIDS on racial and ethnic minorities is a severe and ongoing crisis that requires both immediate measures and a long term sustained commitment to overcome. According to the Centers for Disease Control and Prevention (CDC), AIDS is now the leading cause of death among African American, ages 25 to 44. Racial and ethnic minorities together account for more than 54% of the total AIDS cases reported since the beginning of the epidemic. Latinos account for 18% of the total AIDS cases.

The effect of HIV among substance abusing populations is quite evident -- injection drug use accounts for approximately 59 percent of the reported AIDS cases among women; 52 percent of the reported pediatric AIDS cases; and 30 percent of the total male AIDS cases. This does not take into account AIDS cases related to alcohol and other non-injection drug use (including crack cocaine use). Being under the influence of alcohol and/or drugs, and/or having a mental illness, greatly increases an individual's likelihood of engaging in unsafe sex practices, including having multiple sex partners that can lead to transmitting HIV.

The impact of HIV on the mental health status of persons living with HIV/AIDS is also of critical concern to SAMHSA. To date, more than 711,000 AIDS cases have been reported in the United States, and current CDC estimates suggest that there are 600,000 to 900,000 people infected with the virus. An additional 40,000 new HIV infections are estimated every year. The current public mental health system in this country does not have the capacity to meet all the mental health needs of those infected with the HIV much less those affected by HIV and AIDS. It is important that services addressing the needs of this population are maintained and/or enhanced.

Since its inception, SAMHSA has supported HIV/AIDS related activities through its Centers. SAMHSA's Center for Mental Health Services (CMHS) has supported a portfolio of projects since October 1992,

designed to educate and train traditional and non-traditional mental health care providers to address the mental health needs of HIV/AIDS infected persons and those at risk for HIV infection. Since October 1992, more than 150,000 mental health care providers have received specialized training supported by the CMHS program.

SAMHSA's Center for Substance Abuse Treatment (CSAT) has supported HIV/AIDS related activities through demonstration programs and the Substance Abuse Prevention and Treatment (SAPT) Block Grant. States whose AIDS case rate is 10 or more per 100,000 population, are required to expend 2-5 percent of the block grant to establish one or more projects to make available HIV/AIDS early intervention services at substance abuse treatment sites. In FY 1999, the HIV set-aside will amount to approximately $54.2 million. In addition, SAMHSA's Center for Substance Abuse Prevention (CSAP) has supported HIV prevention activities targeting high risk adolescents through its High Risk Youth Program.

SAMHSA has been increasingly involved to address the interconnected epidemics of substance abuse and HIV/AIDS. In August 1996, SAMHSA along with other Federal agencies and national organizations co-sponsored a forum to bring substance abuse and HIV/AIDS policy makers, and service providers together to improve collaboration and integration of substance abuse and HIV prevention. In addition, SAMHSA's Office on AIDS convened a group of experts from the field to assist in the development of effective plans to ensure that substance abuse prevention and treatment, and mental health are fully integrated with HIV/AIDS prevention strategies and to recommend Knowledge Development and Application (KDA) study questions in the area of HIV/AIDS as it relates to substance abuse prevention and treatment, and mental health. In 1997, SAMHSA co-sponsored national organizations HIV/AIDS conferences, i.e., the Latino Lesbian and Gay Organization (LLEGO), the United States Conference on AIDS, and Men who Have sex with Men Conference. SAMHSA's participation in these most significant conferences will not only improve collaboration efforts, but also encourage information sharing and data gathering and linkages for SAMHSA's activities and development of a strategic plan for HIV/AIDS.

In 1998, SAMHSA developed an interagency agreement to fund the National Association of State and Territorial AIDS Directors (NASTAD) to collect and develop informational data on how the states are collaborating around issues relating to HIV/AIDS and substance abuse. Because the majority of the AIDS cases among African American women and children are directly or indirectly attributable to alcohol and other drug use, SAMHSA has also entered an interagency agreement to fund the National Minority AIDS Council (NMAC) to develop engaging forums to provide a unique opportunity to gather relevant data to assist SAMHSA policy and program staff in developing future strategies to address HIV/AIDS and women related issues. The SAMHSA AIDS Office has initiated the development of a strategic plan for SAMHSA's HIV/AIDS activities and programs. SAMHSA and the Office of National AIDS Policy entered a staff sharing agreement. This arrangement with the Director, Sandy Thurman, worked very well and enhanced linkages between the two offices in addressing further collaboration on substance abuse and mental health issues and HIV/AIDS. As in 1997, in 1998, SAMHSA participated in the US Conference on AIDS in Dallas, Texas, and conducted a three-hour seminar with participation from CSAT grantees.

SAMHSA has played a major role in the development of the HHS response to the Congressional Black Caucus (CBC). SAMHSA staff has participated in all facets of the CBC initiatives and SAMHSA response. These processes have built stronger linkages and collaboration among SAMHSA and the Department to include HRSA, CDC, NIH, and the Office of Minority Health.

In FY 1999, SAMHSA was provided $22 million for the Congressional Black Caucus Initiative for comprehensive substance treatment and prevention programs for certain minority populations at risk for HIV or living with HIV/AIDS. These include:substance abusing African American and Hispanic men (including men who have sex with men), women and young people. The Center for Substance Abuse Treatment and the Center for Substance Abuse Prevention were designed to administer the CBC funded initiatives. The total amount for the FY 2000 CBC initiative is currently $48.8 million.. The initiatives are discussed under the listing of CSAP's and CSAT's HIV/AIDS activities and will continue in FY 2001.

In FY 2000, SAMHSA and its Centers will continue to pursue and participate in collaborative efforts with other Federal agencies such as the CDC, NIH, HRSA, IHS and HFCA as well as our State partners and national constituency organizations to address the multifaceted needs of substance abusers at high risk for HIV infection or living with HIV disease. SAMHSA will utilize information and data gathered from the CBC initiatives and other activities to improve our ability to target activities and linkages that will enable ue to address these dual issues of substance use and HIV infection in a more systematic and effective way.

SAMHSA is committed to developing and implementing a response that both maximizes the effectiveness of existing programs to serve racial and ethnic minority communities confronting HIV/AIDS and substance abuse and mental illness disorders and developing new and innovative strategies that target assistance to address specific needs. With more cases attributable to injecting drug use among African Americans, efforts to stop HIV transmission must include substance abuse prevention and treatment programs and mental health support services as part of the array of strategies being offered.

Center for Mental Health Services

Accomplishments

Mental Health Services Demonstration Program

This program was a collaborative effort of SAMHSA, CMHS, HRSA, HAB, and NIH, NIMH. It was the first Federal effort to develop models of delivery of mental health services to people living with and/or affected by HIV/AIDS. This program has shed new light on how to develop services and develop systems of care. Findings from the program indicated that early intervention with mental health services can improve adherence to medical and other treatments. Mental health treatment services and HIV education play an important role in preventing children and adolescents whose parents have HIV or AIDS from acquiring the virus themselves. These and other important findings are currently being disseminated to the field.

Current/Ongoing Activities

HIV/AIDS High Risk Prevention/Intervention

Project SHIELD: The *HIV/AIDS High-Risk Behavior Prevention/Intervention Model for Young Adults/Adolescents and Women Program* is a collaborative venture aimed at bringing AIDS prevention into the community. Project SHIELD also represents an opportunity to move the field of HIV prevention research forward along the two parallel continuums of innovative intervention design and rigorous evaluation. The multisite nature of this HIV prevention trial has the potential to test the efficacy of two brief interventions and generalize the study results to more than one study population. In essence, the question posed by Project SHIELD is: can the principles underlying demonstrably effective HIV prevention interventions be applied in brief formats to real world clients and still be effective in reducing HIV risk behaviors? Although the HIV prevention field has traditionally relied on self reports of risk behaviors as the primary outcome, Project SHIELD will not only measure participants' self reported behavior change, which may be biased, but will *actually* measure reductions in diseases; diseases such as common STDs that are associated with considerable adverse sequelae and may facilitate HIV transmission.

HIV/AIDS Mental Health Provider Education Program

The *HIV/AIDS* Mental Health Care Provider Education Program completed its final year of funding in FY 1998. In 1998 the Mental Health Provider Education in *HIV/AIDS* Program II was created to evaluate the dissemination of knowledge on (1) the psychological and neuropsychiatric sequelae of HIV/AIDS, and (2) the ethical issues in providing services to people with HIV/AIDS, to both traditional and nontraditional first-line providers of mental health services, and to evaluate the relative effectiveness of different education approaches. Training approaches are incorporating the most current research-based information and allow easy modifications to reflect changes in the medical regimen for treatment of AIDS.

The HIV/AIDS Treatment Adherence/Health Outcome and Costs Study

The HIV/AIDS Treatment Adherence/Health Outcome and Costs Study reflects the collaboration of six Federal entities—the Center for Mental Health Services, which has lead administrative responsibility, and the Center for Substance Abuse Treatment, both of which are components of the Substance Abuse and Mental Health Services Administration (SAMHSA); the HIV/AIDS Bureau in the Health Resources and Services Administration (HRSA); and the National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse, all components of the National Institutes of Health (NIH). The HIV/AIDS Cost Study is the first-ever Federal initiative designed to study integrated mental health, substance use, and primary medical HIV treatment interventions. More importantly, the study is the first Federal effort to determine if an integrated approach to care improves treatment adherence, produces better health outcomes, and reduces the overall costs associated with HIV treatment.

Center for Substance Abuse Prevention

Substance Abuse and HIV/AIDS Prevention for Youth and Women of Color: This $6 million effort, initiated in FY 1999, responds to the pressing "state of emergency" that exists with respect to the extent and impact of HIV/AIDS on the Black community as highlighted by members of the Congressional Black Caucus (CBC). The overwhelming majority of AIDS cases among African American women and children is directly or indirectly attributable to alcohol or illicit drug use. The CBC has characterized the burden of HIV/AIDS on racial and ethnic minorities as a severe and ongoing crisis which requires both immediate measures and a long term commitment to resolve. The Substance Abuse and HIV/AIDS Prevention for Youth and Women of Color Initiative focuses on providing HIV/substance abuse prevention services to African American and Hispanic youth and women, with a particular focus on designated hard-hit communities and building capacity for improved training and technical assistance.

A major component of this initiative is a Substance Abuse/HIV Prevention Targeted Capacity Expansion program which provides funds to community-based organizations, Historical Black Colleges and Universities, Hispanic Colleges and Universities, Faith communities, and other coalitions and/or partnerships for the purpose of strengthening the integration of HIV and substance abuse prevention services at the local level and increasing the provision of integrated services to African American and Hispanic youth and women. The HIV/AIDS initiatives will also work with CSAP's Centers for the Application of Prevention Technology (CAPTs) to enable them to integrate HIV prevention into their substance abuse prevention materials and curricula and to help build capacity within the CAPTs to provide training and technical assistance to community based organizations and other providers in the hardest hit communities. Finally, the HIV/AIDS initiative will partner with national organizations to undertake several key roles, including accessing and retaining minority youth and women in prevention programs, ensuring the applicability and feasibility of proposed community programs, coordinating and convening the component service and training programs of the initiative, and providing technical assistance to the CAPTs in the incorporation of HIV prevention within substance abuse prevention materials and curricula available from them. CSAP plans to continue this program in FY 2001.

Center for Substance Abuse Treatment

In FY 1999, CSAT was appropriated $16 million to address the issue of the crisis that exists with respect to the extent and impact of *HIV/AIDS in the Black Community* as highlighted by members of the Congressional Black Caucus (CBC). In response to this issue and the increasing number AIDS case rate among minorities, CSAT awarded grants 36 community-based organizations to augment, expand and enhance substance abuse treatment services, HIV/AIDS and infectious disease services. In addition, CSAT also funded 25 HIV Outreach Projects that are designed to target hard-to-reach, high-risk substance abusers with prevention and behavioral risk information and to facilitate their early entry into substance abuse treatment. These grants were restricted to metropolitan areas with AIDS case rates of 25 per 100,000 or higher and States with AIDS case rates of 10 or more per 100,000 (as reported in the CDC's HIV/AIDS Surveillance Report). These funds will be earmarked for comprehensive substance

abuse treatment programs for substance abusing African American and Hispanic populations at risk of contracting HIV, including women and their children and men who have sex with men (MSM).

CSAT plans to continue the agenda set by the Congressional Black Caucus in FY 1999 which was expanded in the FY 2000 appropriation, and further expand (+$15 million) the HIV/AIDS TCE initiative in African American, Hispanic and other ethnic/racial minority communities in FY 2001.

Substance Abuse Block Grant HIV/AIDS Activities

Current SABG guidance for allocation of block grant funds to the States requires that 2% - 5% of the allocation must be spent on HIV/AIDS-related substance abuse programs in States with an AIDS case rate of 10 per 100,000 population (estimated at approximately $54 million from the total block grant funding for FY 2000).